MARYLAND STATE DEPARTMENT OF HEALTH

WITHIN CORPORATE LIMITS

Bureau of Vital Statistics, Baltimore 47-d C13

Reg. Dist. No. 9

CERTIFICATE OF DEATH

05000

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Frostburg (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Miners Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 2 weeks

(e) Length of stay in this community (yrs., mos., or days) 2 weeks

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State D. C. (b) County

(c) City or town Washington (If outside city or town limits, write RURAL and give town)

(d) Street No. 11 Kennedy St., N.E. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME James Hamilton Allerdice

3 (b) If veteran, name war: no

3 (c) Social Security No. 577-03-0481

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Margaret Neff Allerdice

6. (c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) May 29, 1901

8. AGE: Years 38 | Months 11 | Days 14 | If less than one day hr. min.

9. Birthplace Lonaconing, Allegany, Md. (Town, county, and state)

10. Usual occupation Bookkeeper

11. Industry or business Mfg. of Beer

FATHER 12. Name Thomas Allerdice

FATHER 13. Birthplace Lonaconing

MOTHER 14. Maiden Name Margaret Hamilton

MOTHER 15. Birthplace Lonaconing

16 (a) Informant Oliver Sindorf

(b) Address W. Loo St., Frostburg, Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 16, 1940 (month) (day) (year)

(c) Cemetery or crematory Alleg. Cemetery, Frostburg

Location Frostburg, Md.

18 (a) Funeral director Jacob Hafer

(b) Address 23 East Main St. Frostburg Md.

19 (a) 5-17-1940 (Date rec'd by registrar) (b) Mrs. A. R. Wachter Registrar

MEDICAL CERTIFICATION

20. Date of death 5-13 1940, at 10:12 P.M

21. I certify that death occurred on the date above stated; that I attended deceased from 4-29 1940, to 5-13 1940, and that I last saw him alive on 5-13 1940.

Immediate cause of death	Duration
Carcinoma of Lung (right)	6 mos.
acute nephritis	2 wks.
Due to	
Due to	
Other conditions none.	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature H. C. Diehl, M.D. (M. D. or other)

Address Frostburg, Md. Date signed 5/15/40

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (166)

CERTIFICATE OF DEATH

05801

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Virginia County: Mineral

City or town: Ridgeley Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 7 Blocher
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ✓

3. (a) FULL NAME: Kermit Quinton Bailey

3. (b) Social Security Number: 234-14-0906

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Name Unknown

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 6, 1916

8. AGE: Years	Months	Days	If less than one day
24	4	7	hrs. min.

9. Birthplace: Preston Co. W. Va.
(Town, county, and state)

10. Usual occupation: Restaurant Work - dish washer

11. Industry or business: Porter's Restaurant

FATHER 12. Name: Arthur Bailey

FATHER 13. Birthplace: W. Va.

MOTHER 14. Maiden name: Rebecca Miller

MOTHER 15. Birthplace: W. Va.

16. Informant: Saby Turner

Address: Morgantown, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 16, 1940 (month) (day) (year)

Cemetery or crematory: East Oak Grove

Location: Morgantown, W. Va.

18. Funeral director: Jenkins & Brown

Address: Morgantown, W. Va.

19. May 14 19 40 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13, 19 40, at 9.30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__,

and that I last saw h__ alive on ____ 19__.

Immediate cause of death	DURATION
Homocide, gunshot	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: none

Of autopsy: none

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: homocide Date of: 5/13/40

Where did injury occur? Cumberland, Allegany, Maryland.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): Riverside Park

Means of injury: gun shot Injured at work? no

23. SIGNATURE: Prince H. Conner, M.D.
M. D. or other

Address: Cumberland, Maryland Date signed: 5/14/40

Deputy Medical Examiner - Allegany Co.

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940) nfcb

05002

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 24 N. Chase St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 2 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County Wood

City or town Parkersburg W. Va. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1408 Spring St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Lida May Barrett

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 26 1881

8. AGE: Years 58 | Months 9 | Days 21 | If less than one day hrs. min.

9. Birthplace Parkersburg, Wood Co, W. Va.

(Town, county and state)

10. Usual occupation Housework

11. Industry or business At Home

FATHER 12. Name John R. Barrett

13. Birthplace Parkersburg W. Va.

MOTHER 14. Maiden name Laura E. Vaughan

15. Birthplace Parkersburg W. Va.

16. Informant Wm. F. Goodwin

Address 24 N. Chase St

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20 1940 (month) (day) (year)

Cemetery or crematory Mt. Olivet

Location Parkersburg W. Va.

18. Funeral director Jacob Hafer

Address Cumberland Md.

19. May 18 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-17-40 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from never 19 , to 19 , and that I last saw h alive on 19

Immediate cause of death	DURATION
Dead on arrival.	
apparently Cardiac	
Failure.	
Due to Primary cause: Coronary thrombosis	
Due to duration: six or seven weeks.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Alfred Van Ormer M. D. or other

Address 40 N. Liberty St. Cumberland, Md. Date signed 5-18-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4-C)

CERTIFICATE OF DEATH

05003

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Island St.
Stay in hospital or inst. (yrs., or mos., or days): c
Stay in this community (yrs., or mos., or days): 58 yrs. 8 mos. 13 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Island
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: c

3. (a) FULL NAME: Catherine Pendleberry Beaman

3. (b) Social Security Number: c

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Jesse Beaman
6(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): Aug. 30, 1881

8. AGE: Years: 58 | Months: 8 | Days: 13 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Lonaconing, Allegany Co., Md.
(Town, county and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER
12. Name: Eli Pendleberry
13. Birthplace: England

MOTHER
14. Maiden name: Catherine Lloyd
15. Birthplace: England

16. Informant: Jesse Beaman
Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year): May 15, 1940
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing, Md.

18. Funeral director: M. Eichhorn
Address: Lonaconing, Md.

19. May 15 1940 (Date rec'd by registrar) E. Doe Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1940, at 4 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 2 1940, to May 13 1940, and that I last saw h[illegible] alive on May 12 1940.

	DURATION
Immediate cause of death: carcinoma of stomach	4 months
Due to:	
Due to:	
Other conditions: Diabetes	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D.
M. D. or other
Address: Lonaconing, Md. Date signed: May 15 '40

RECEIVED
JUN 5 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

05004

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (2)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days): none
Stay in this community (yrs., or mos., or days): none

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany.
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 500 N. Centre St.
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME: Stillborn Bennett

3. (b) Social Security Number

4. Sex: Male
5. Color or race: white
6. (a) Single, married, widowed, or divorced: Infant
6 (b) Name of husband or wife
6(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.): May 14, 1940.

8. AGE: Years: 0 Months: 0 Days: 0 If less than one day: 0 hrs. 0 min.

9. Birthplace: Cumberland Md.
(Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name: Paul Bennett.
13. Birthplace: Flintstone, Md

MOTHER
14. Maiden name: Garnet Farlow
15. Birthplace: Great Cacon, W. Va.

16. Informant: Allegany Hospital
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 16, 1940. (month) (day) (year)
Cemetery or crematory: Fairview Cemetery
Location: Bedford Co. Penna.

18. Funeral director: Ephraim Smith
Address: Artemus, Penna.

19. May 15 1940 (Date rec'd by registrar) J.P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14 1940, to May 14 1940, and that I last saw him alive on May 14 1940.

Immediate cause of death: Developmental, Abnormality, Anencephalus
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings: W
Of operations
Of autopsy W

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide W Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) W
Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 1332 N. Ave Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

05005

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 323 Columbia St

Stay in hospital or inst. (yrs., or mos., or days) 7 day

Stay in this community (yrs., or mos., or days) 22 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 323 Columbia St

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR no

3. (a) FULL NAME Ella Bird Berry

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	Widowed

6 (b) Name of husband or wife Geo. Berry

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Nov. 23, 1851

8. AGE:

Years	Months	Days	If less than one day
88	5	18	____ hrs. ____ min.

9. Birthplace Federman W Va.

(Town, county, and state)

10. Usual occupation House keeper

11. Industry or business At Home

FATHER

12. Name Felix Laing

13. Birthplace Not Known

MOTHER

14. Maiden name Emily Robinson

15. Birthplace Not Known

16. Informant Mrs Lola Lillis

Address 323 Columbia St

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 13 1940 (month) (day) (year)

Cemetery or crematory Fort Ashby

Location Fort Ashby W Va.

18. Funeral director Jacob Hofer

Address Cumberland

19. May 13 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1940 at 11.00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 5 1934, to May 11 1940, and that I last saw her alive on May 11 1940.

Immediate cause of death Chronic Cerebro Vascular disease from age

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION 1934

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury no Injured at work?

23. SIGNATURE M E B Owens M. D. or other

Address 33 Kane Date signed May 12 1940

M. E. B. Owens

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

05006

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 522 Beall St
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants, give residence of mother)
State Md County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 522 Beall St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Birmingham

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife William B Birmingham
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 15 1872

8. AGE:

Years	Months	Days	If less than one day
67	8	11	hrs. min.

9. Birthplace Lonaconing Md
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own home
FATHER 12. Name Patrick Conway
13. Birthplace Ireland
MOTHER 14. Maiden name Anna Ryan
15. Birthplace Mt Savage Md
16. Informant Mrs Wm B Birmingham
Address Cumberland, Md.
17. Burial Date thereof May 29. 40
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St Michael
Location Frostburg Md
18. Funeral director Louis Stein Inc
Address Cumberland Md
19. May 28, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-26-40 19 , at 9A M

I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-20-40 19 , to 5-26 19 40, and that I last saw h alive on 5-25-40 19 .

Immediate cause of death Apoplexy — DURATION 3 days
Due to
Due to
Other conditions Embolism of Rt Leg.
(Include pregnancy within 3 months of death)
Major findings:
Of operations None
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. Zimmerman M.D.
M. D. or other
Address Cumberland Md Date signed 5-27-40

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 63-E CP

05007

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days) 25 DAYS
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VIRGINIA County HAMPSHIRE
City or town RADA Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME COLUMBIA BOBO, MRS.

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife HERMAN BOBO
6(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) FEBRUARY 3, 1880

8. AGE: Years	Months	Days	If less than one day
60	3	8	hrs. min.

9. Birthplace WEST VIRGINIA (Town, county, and state)
10. Usual occupation HOUSEWIFE
11. Industry or business

FATHER
12. Name JOHN ROADCAP
13. Birthplace VIRGINIA

MOTHER
14. Maiden name ALICE SHUMAKER
15. Birthplace WEST VIRGINIA

16. Informant Herman Bobo
Address Rada, W. Va.

17. Removal (Burial, cremation, or removal. Which?) Date thereof May 13, 1940 (month) (day) (year)
Cemetery or crematory Old Pine Cem.
Location Burgettsville, W. Va.

18. Funeral director Shrecks
Address Romney, W. Va.

19. May 11 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION 7:35 & 7:35

20. DATE OF DEATH MAY 11 19 40, at A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 25, 1940, to May 11, 1940, and that I last saw her alive on May 10, 1940.

Immediate cause of death Thyrotoxicosis toxicosis — DURATION 1936
Due to Auricular Fibrillation
Due to Hypertension
Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Mary E. Durrett, M. D. or other
Address Cumberland, Md. Date signed May 14, 1940

DR. DURRETT

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73)

CERTIFICATE OF DEATH

05008

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 5 Weber

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Westernport Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Hugh Bothwell

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widower

6 (b) Name of husband or wife Mary Bothwell

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 12, 1861

8. AGE: Years	Months	Days	If less than one day
78	7	1	hrs. min.

9. Birthplace Scotland (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business own Farm

FATHER 12. Name William Bothwell

FATHER 13. Birthplace Scotland

MOTHER 14. Maiden name Margia Ardyboughs

MOTHER 15. Birthplace Scotland

16. Informant E. J. Bothwell

Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 16, 1940 (month) (day) (year)

Cemetery or crematory Philos

Location Westernport, Md.

18. Funeral director D. J. Beal

Address Westernport, Md.

19 May 15 19 40 J. P. Franklin, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 19 40, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 40, to May 14 19 40

and that I last saw h- alive on May 14 19 40.

Immediate cause of death Chronic Myocarditis — DURATION 3 yrs

Due to

Due to

Other conditions Arteriosclerosis — 2 yrs.

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P. N. Trevaskis M.D.

M. D. or other

Address Cumberland, Md. Date signed May 14, 40

RECEIVED
JUN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

WITHIN CORPORATE LIMITS

CERTIFICATE OF DEATH

050099

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 196 Mechanic

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg Md. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 196 Mechanic St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Rachel Broode

3. (b) Social Security Number: none

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	widowed

6 (b) Name of husband or wife: Conrad Broode

6(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): Nov 15 - 1863

8. AGE: Years	Months	Days	If less than one day
76	5	29	hrs. min.

9. Birthplace: Lonaconing, Allegany, Md. (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER — 12. Name: Charles Kingwood

13. Birthplace: Scotland

MOTHER — 14. Maiden name: Mary Duckworth

15. Birthplace: Lonaconing, Md.

16. Informant: Catherine Broode

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 15 - 1940 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg, Md.

18. Funeral director: J. J. Dugan

Address: Frostburg, Md

19. 5-14 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 1940, at 2:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13 1940 to May 13 1940, and that I last saw h- alive on April 13 1940.

Immediate cause of death: Bronchopneumonia

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A. M. Eade Jr M.D. or other

Address: 600 Main St Frostburg Md

RECEIVED
JUN 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

05010

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 451 Pine St
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 451 Pine St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Infant Brooks

3. (b) Social Security Number None

4. Sex: Female | 5. Color or race: Colored | 6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 16, 1940

8. AGE: Years | Months | Days | If less than one day: 18 hrs. 15 min.

9. Birthplace Cumberland, Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Benjamen Broom

13. Birthplace md

MOTHER 14. Maiden name Bertie Brooks

15. Birthplace md

16. Informant Bertie Brooks

Address 451 Pine St

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 16 1940 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Cumberland Md

18. Funeral director Louis Stein Inc.

Address Cumberland Md

19. May 18 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 1940, at 1030 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 1940, to May 17 1940, and that I last saw her alive on May 16 1940

	DURATION
Immediate cause of death Asphyxia	
Due to Premature Birth	15 hours
Due to ?	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George C. Holloway M. D.
M. D. or other
Address 146 Hanover St. Date signed May 17 40

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

05011

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 21 Prospect Square

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 21 Prospect Square
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Boyd Bucy 531-07-4549 (Ross) 3. (b) Social Security Number None

4. Sex male | 5. Color or race, white | 6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 14, 1882

8. AGE: Years 58 | Months 2 | Days 4 | If less than one day hrs. min.

9. Birthplace Allegany Co., Maryland
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Building Contractor

FATHER
12. Name William Bucy
13. Birthplace Allegany Co., Maryland

MOTHER
14. Maiden name Unknown
15. Birthplace "

16. Informant Mrs. Marshall Hartrock

Address 21 Prospect Square

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20 1940 (month) (day) (year)

Cemetery or crematory Hill Crest Cemetery

Location Cumberland, Md.

18. Funeral director Jacob Hofer

Address 230 Baltimore Ave.

19 May 20, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1940, at 6 20 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14 1940, to May 18 1940, and that I last saw him alive on May 14 1940.

Immediate cause of death Chronic myocarditis | DURATION 2 yrs

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. W. Trevaskis, M.D.
M. D. or other

Address Cumberland, Md Date signed May 18-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

05012

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (195-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 400 Grand Ave.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Hugh Henry Burns.

3. (b) Social Security Number none

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21 1874

8. AGE: Years 65 Months 10 Days 20 If less than one day hrs. min.

9. Birthplace Grafton, W. Va.
(Town, county, and state)

10. Usual occupation General work

11. Industry or business Retired 10 yrs

FATHER
12. Name Hugh Burns.
13. Birthplace Ireland

MOTHER
14. Maiden name Ann Hanly
15. Birthplace Ireland.

16. Informant Michael J Burns
Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 14 40 (month) (day) (year)

Cemetery or crematory Sts Peters Cem.

Location Westernport Md

16. Funeral director Louis Stein Inc
Address Cumberland Md.

19. May 14, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11-1940. 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/1/40 19 , to 5/11/40. 19 ,
and that I last saw him alive on 5/11/40. 19 ,

Immediate cause of death Peritonitis. DURATION 5/1/40.

Due to Piece of meat-bone piercing, or puncturing, small intestine from within

Due to C.W.G.R.

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John K. Rozman M.D. M. D. or other

Address Cumberland Md Date signed 5/11/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

05013

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 340 Frederick St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 340 Frederick St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William H. Campbell

3. (b) Social Security Number None

4. Sex Male

5. Color or race Colored

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Mary M Minor

6 (c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Jan 6 1850

8. AGE: Years 90 Months 4. Days 15 If less than one day ____ hrs. ____ min.

9. Birthplace Frederick Md
(Town, county, and state)

10. Usual occupation Waiter

11. Industry or business Hotel

FATHER
12. Name Robert Campbell
13. Birthplace Md

MOTHER
14. Maiden name Mathilda Hawkins
15. Birthplace Md

16. Informant Helen Burnett

Address Cumberland Md

17. Burial (Burial, cremation, or removal Which?) Date thereof May 24 1940 (month) (day) (year)

Cemetery or crematory Summer Cem

Location Cumberland Md

18. Funeral director Louis Stein Inc

Address Cumberland Md

19. May 24 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1940, at 8:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14, 1940, to May 21 1940, and that I last saw him alive on May 20 1940.

Immediate cause of death Chronic Myocarditis
Duration: not stated. C.W.S.R.

Due to Arteriosclerosis

Due to

Other conditions —
(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

DURATION
?
?

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE George C. Holloman M.D. M. D. or other

Address 145 Hanover St. Date signed May 23.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

CERTIFICATE OF DEATH

05014

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 700 Grand Ave
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 50 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 700 Grand Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Edward J Castle

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife Mary S Peters
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 7 1857

8. AGE:

Years	Months	Days	If less than one day
82	11	6	hrs. min.

9. Birthplace Frederick Md
(Town, county, and state)
10. Usual occupation Conductor Ry. Retired
11. Industry or business
FATHER 12. Name James Castle
13. Birthplace Germany.
MOTHER 14. Maiden name Mary C Hoffman
15. Birthplace Unknown
16. Informant Mrs Earl J Beeche.
Address Cumberland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15 '40 (month) (day) (year)
Cemetery or crematory Rose Hill Cem.
Location Cumberland
18. Funeral director Louis Stein Inc.
Address Cumberland.
19. May 16 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1940, at 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 25 1940, to May 13 1940, and that I last saw h alive on May 17 1940.

Immediate cause of death — DURATION
Chronic Myocarditis
Chronic Nephritis
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Richard J. Williams M.D.
M. D. or other
Address 34 Va. Ave. Date signed 5/15/40

RECEIVED
JUN 6 1940
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15-C)

05015

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:
County: Alleganey
City or town: Westernport
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Reeves Clinic
Stay in hospital or inst. (yrs., or mos., or days): 3 days
Stay in this community (yrs., or mos., or days): 14 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Alleganey
City or town: Westernport Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 334 Front
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mary Cavalloro

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Larry Cavalloro
6(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): June 7, 1907

8. AGE: Years	Months	Days	If less than one day
32	10	25	hrs. min.

9. Birthplace: Eckhart, Alleganey, Md. (Town, county, and state)
10. Usual occupation: House-wife
11. Industry or business: Home

FATHER
12. Name: Peter Scarsella
13. Birthplace: Italy

MOTHER
14. Maiden name: Rachela Granata
15. Birthplace: Italy

16. Informant: Larry Cavalloro
Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 4, 1940 (month) (day) (year)
Cemetery or crematory: St. Peters
Location: Westernport, Md.
18. Funeral director: D. S. Boal.
Address: Westernport, Md.

19. May 3 1940 (Date rec'd by registrar) A. Bayne Baker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 2 1940, at 1230 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 26th 1940, to May 2, 1940, and that I last saw h-- alive on May 1 1940.

Immediate cause of death	DURATION
Vincents Angina	10 days
Gastro-enteritis - internal	4 "
Due to Hemorrhage	1
Acute Myocardial failure	5-2-40
Due to That gastro intestinal Hemorrhage was due to ulcer of the stomach	
Other conditions: Duration - two days.	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy: no

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: injured at work?

23. SIGNATURE: Norman Reeves, M.D. M. D. or other
Address: Westernport, Md. Date signed 5-3-40

RECEIVED
JUN 5 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

05016

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 1/2 day

Stay in this community (yrs., or mos., or days) 30 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 320 Bond St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John T Cavanaugh.

3. (b) Social Security Number 214-05-6234

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Letta May Wise

6(c) If alive, give age 45 years

7. Birth date of deceased (mo., day, yr.) July 22, 1889

8. AGE: Years 50 Months 9 Days 19 If less than one day ___ hrs. ___ min.

9. Birthplace Midland, Md.
(Town, county, and state)

10. Usual occupation ~~Dennis~~ Gas Station Prop.

11. Industry or business

FATHER
12. Name Dennis Cavanaugh.
13. Birthplace Ireland.

MOTHER
14. Maiden name Jane Gordon
15. Birthplace England.

16. Informant John T Cavanaugh Jr.
Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 14 40 (month) (day) (year)

Cemetery or crematory St Patricks Cem.

Location Cumberland.

18. Funeral director Louis Stein Inc
Address Cumberland

19. May 13, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/11/40. 19 , at 8 P M

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from 5/11/40 19 to 5/11/40 19 , and that I last saw him alive on 5/11/40 19

Immediate cause of death ~~Cardiac~~ Coronary thrombosis

DURATION 5 hours.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John K Rosum MD M. D. or other

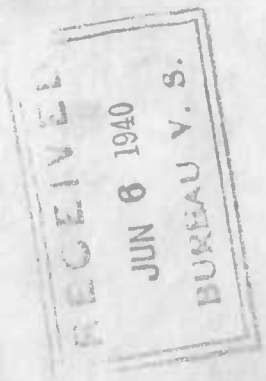
Address Cumberland Md Date signed 5/13/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Rozum.



WITHIN CORPORATE LIMITS.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-B)

05017

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Route #2

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 85 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Route #2
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Lee Roy Chaney

3. (b) Social Security Number None

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Alberta "Christie" Chaney

6(c) If alive, give age 84 years

7. Birth date of deceased (mo., day, yr.) Dec. 9, 1854

8. AGE: Years 85 Months 5 Days 4 If less than one day ___ hrs. ___ min.

9. Birthplace Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation Real Estate

11. Industry or business Own Business

FATHER
12. Name Isaac Chaney
13. Birthplace Cumberland, Md.

MOTHER
14. Maiden name Henrietta Roberts
15. Birthplace Cumberland, Md.

16. Informant Mrs John N. Yonker

Address Balto. Pike. Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15, 1940 (month) (day) (year)

Cemetery or crematory Pleasant Grove Cemetery

Location Balto Pike - Cumberland, Md.

18. Funeral director Jacob Hafer

Address Cumberland Maryland

19. May 15 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1940, at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1940, to May 13 1940, and that I last saw him alive on May 12 1940.

Immediate cause of death	DURATION
Chronic myocarditis	4 yrs
Due to Chronic nephritis	4 yrs
Due to Chronic endocarditis	4 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos. N. Koon M. D. ~~or other~~

Address Cumberland Md Date signed May 14/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (55-2)

05018

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND MD. (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
MEMORIAL HOSPITAL
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State ALLEGANY County STATE MARYLAND
City or town CUMBERLAND (If outside city or town limits, write RURAL NEAR and give town) Ward No.
Street No. 2 NEW HAMPSHIRE AVE.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME
MR. VANCE CLEM

3. (b) Social Security Number
214-05-5673

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife MILDRED FISHER
6(c) If alive, give age 27 years

7. Birth date of deceased (mo., day, yr.) JUNE 2, 1908

8. AGE: Years	Months	Days	If less than one day
31	11	28	hrs. min.

9. Birthplace WEST VIRGINIA (Town, county, and state)
10. Usual occupation Barber
11. Industry or business Turner's Barber Shop
FATHER 12. Name JESSE CLEM
13. Birthplace WEST VIRGINIA
MOTHER 14. Maiden name BARBARA BANE
15. Birthplace WEST VIRGINIA

16. Informant MRS. J.V. CLEM
Address 2 NEW HAMPSHIRE AVE. CUMBERLAND, MD.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 2, 1940 (month) (day) (year)
Cemetery or crematory Hillcrest Cem
Location Cumberland Md.
18. Funeral director Louis Stein dm
Address Cumberland Md.
19. June 2 1940 (Date rec'd by registrar) J.P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

MAY 30, 1940 1;00 A.M.

20. DATE OF DEATH ..... 19 ....., at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-11- 1940, to 5-30- 1940, and that I last saw him alive on 5-29- 1940.

Immediate cause of death	DURATION
Carcinoma of thymus.	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings: none.
Of operations
Of autopsy Confirmation of diag.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm. F. Williams M. D. or other
Address Cumberland Date signed 5/31/40.

DR. W. F. WILLIAMS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

05019

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: ALLEGANY

County

City or town CUMBERLAND, MARYLAND (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 409 CENTRAL AVE., (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME MR. WILLIAM B. COOK

3. (b) Social Security Number 220-10-0303

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife MARY ELIZ. MEACHER

6(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) SEPT. 19, 1863

8. AGE: Years	Months	Days	If less than one day
76	8	8	hrs. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation Elevator man

11. Industry or business Kelly Springfield Tire Co

FATHER 12. Name CHARLES T. COOK

FATHER 13. Birthplace MARYLAND

MOTHER 14. Maiden name GEORGIANA PLUMMER

MOTHER 15. Birthplace MARYLAND

16. Informant MRS. WILLIAM COOK

Address 409 CENTRAL AVE., CUMBERLAND, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 29 40 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md

18. Funeral director Lewis Steinbrun

Address Cumberland, Md

19. May 28 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. DURRETT

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 27, 1940 19 , at 3:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25, 1940, to May 27, 1940, and that I last saw him alive on May 27, 1940.

	DURATION
Immediate cause of death: Arteriosclerotic Cardio-Vascular Disease	1938
Due to Uraemia	May 1 '40
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clay E. Turner M. D. or other

Address Cumberland, Md Date signed 5/28/40

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1081)

CERTIFICATE OF DEATH

05020

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 24 hrs.

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Westernport Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 222 Front St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mary George Coury

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Manson Coury

6(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): April 20, 1885

8. AGE:

Years	Months	Days	If less than one day
55	1	0	hrs. min.

9. Birthplace: Mt. Lebanon, Penna (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER — 12. Name: George Lysander

FATHER — 13. Birthplace: Mt. Lebanon, Penna

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace:

16. Informant: Mr. Manson J. Coury

Address: 222 Front St. Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 23, 1940 (month) (day) (year)

Cemetery or crematory: St. Peters Cemetery

Location: Westernport

18. Funeral director: D. S. Beal

Address: Barton, Md.

19. May 23 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20, 1940, at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5.19. 1940, to 5.20. 1940 and that I last saw her alive on 5.20. 1940

Immediate cause of death: Lobar Pneumonia — DURATION: 3 days.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wm F. Williams M. D. or other

Address: Cumberland Date signed: 5.22.40.

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05021

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: Alleg Hospital

Stay in hospital or Inst. (yrs., or mos., or days) 3 wks

Stay in this community (yrs., or mos., or days) 6 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 126 Arnette Terrace
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Elinor G. Cunningham

3. (b) Social Security Number None

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 20 1925

8. AGE: Years 14 Months 7 Days 2 If less than one day hrs. min.

9. Birthplace Morristown N. J.
(Town, county, and state)

10. Usual occupation Student

11. Industry or business

FATHER
12. Name Geo F Cunningham
13. Birthplace West Va.

MOTHER
14. Maiden name Elinor Jamison
15. Birthplace Md

16. Informant Alice M Cunningham
Address Cumberland Md

17. Buried
(Burial, cremation, or removal. Which?)
Date thereof 5/24/40 (month) (day) (year)

Cemetery or crematory Rose Hill

Location Cumberland Md

18. Funeral director Louis Stein Inc
Address Cumberland Md

19. May 24 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1940, at 4 10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1940, to May 22 1940 and that I last saw her alive on May 22 1940.

Immediate cause of death Acute Endocarditis

DURATION 22 dys

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T Johnson Jr. M. D. or other

Address Cumberland, Md Date signed 5-24-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1940
BUREAU V. S.

Dr. Earle

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-a)

WITHIN CORPORATE LIMITS

CERTIFICATE OF DEATH

Reg. Dist. No. 05022

1. PLACE OF DEATH:

County: Allegany

City or town: Shaft Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: R.F.D. 1, Frostburg, Md.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Shaft Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: R.F.D. 1, Frostburg, Md.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Gertrude Johnson Davis

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Wm Davis

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 6, 1878

8. AGE: Years: 62 Months: 0 Days: 0 If less than one day ____ hrs. ____ min.

9. Birthplace: Kingwood W. Va (Town, county, and state)

10. Usual occupation: School teacher

11. Industry or business: Public School

FATHER

12. Name: James T. Johnson

13. Birthplace: Morgantown W. Va.

MOTHER

14. Maiden name: Rosalie Duvall

15. Birthplace: Kingwood, W. Va

16. Informant: Mrs. John Durst

Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 8, 1940 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg Md.

18. Funeral director: J. J. Durst

Address: Frostburg Md.

19. May 8th 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 1940, at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1940, to May 4 1940, and that I last saw her alive on May 4 1940.

Immediate cause of death: Bronchopneumonia

Due to

Due to

Other conditions: Carcinoma cervix metastases to Femur

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: A. M. Earle Jr. M.D. or other

Address: Townsville Frostburg Md. Date signed: May 7 1940

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 3 1940
BUREAU V. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (79)

CERTIFICATE OF DEATH

05023

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: a-St La Vale
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland, md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. a-St- La Vale
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Francis Elizabeth Drussman

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband ~~or wife~~ Frank John Drussman
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 31 1897

8. AGE: Years	Months	Days	If less than one day
42	8	15	hrs. min.

9. Birthplace Cumberland, md (Town, county, and state)
10. Usual occupation housewife
11. Industry or business Own home

FATHER
12. Name Fredrick Maffley
13. Birthplace Germany

MOTHER
14. Maiden name Frances Helmstetter
15. Birthplace Germany

16. Informant Frank Drussman
Address a-St La Vale

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20 1940 (month) (day) (year)
Cemetery or crematory St. Patrick + Paul
Location Cumberland, md
18. Funeral director Louis Stein Inc
Address Cumberland md.

19. May 18 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 16 Th 1940, at 11 1/2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1940, to May 16 1940, and that I last saw her alive on May 16 Th 1940.

Immediate cause of death	DURATION
Mesenteric Embolism	4 1/2 hr.
Due to Thrombosis of Mesenteric Vein	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. C. Bowen M.D. M. D. or other
Address Cumberland Md Date signed 5-17-40

RECEIVED
JUN 6 1940
BUREAU V. S.

Burnes

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131 E)

05024

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 day

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: Sylvan Retreat (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: David Duckworth

3. (b) Social Security Number: none

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): about 1878

8. AGE: Years: 62 Months: Days: If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: None.

11. Industry or business:

FATHER: 12. Name: Aaron Duckworth

13. Birthplace: W. Va.

MOTHER: 14. Maiden name: Mary G Shroyer

15. Birthplace: Pa.

16. Informant: Sylvan Retreat

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 10 40 (month) (day) (year)

Cemetery or crematory: Allegany Co. Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland.

19. May 9 1940 (Date rec'd by registrar) J. P. Franklin M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5 - 8 - 1940, at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 7, 1939, to 5-8-1940 and that I last saw him alive on 5-8-1940.

Immediate cause of death: Chronic Myocarditis ?

Due to: Chronic Nephritis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations: None

Of autopsy: None

DURATION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wm. L. Williams M. D. or other

Address: Cumberland Date signed: 5/8/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-a)

CERTIFICATE OF DEATH

05025

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS/A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 370 Cumberland St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Henry K Duke, Jr

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 23 - 1940

8. AGE: Years | Months | Days 7 | If less than one day hrs. min.

9. Birthplace Cumberland Md
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Henry K Duke
13. Birthplace Cumberland Md

MOTHER 14. Maiden name Elizabeth Munro
15. Birthplace Md

16. Informant H K Duke
Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 27 '40 (month) (day) (year)

Cemetery or crematory Rolleston Cem

Location Cumberland

18. Funeral director Louis Stein

Address Cumberland Md.

19. May 27 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1940, at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 23, 1940 to May 25 1940, and that I last saw h[illegible] alive on May 25 1940

Immediate cause of death Intracranial Hemorrhage — DURATION 2 days

Due to Premature Labor

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy Intracranial Hemorrhage

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE W Royce Hodges, M D

Address Cumberland, Md — M. D. or other

Date signed 5/27/40

RECEIVED
JUN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore 1142

Reg. Dist. No. 9

WITHIN CORPORATE LIMITS

CERTIFICATE OF DEATH

05026

1. PLACE OF DEATH

(a) County Allegany

(b) City or town Frostburg Md.
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: Memorial Hospital

(d) Length of stay in hospital or inst. (yrs., mos., or days) 7 wks

(e) Length of stay in this community (yrs., mos., or days) 47 yrs.

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md (b) County Allegany

(c) City or town Frostburg
(If outside city or town limits, write RURAL and give town)

(d) Street No. 15 Lee Street
(If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** Annie Catherine Eckley

3 (b) If veteran, name war

3 (c) Social Security No. None

4. Sex: Female

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Jas. E. Eckley

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Aug 15 1891

8. AGE: Years 49 | Months 4 | Days 25 | If less than one day _____ hr. _____ min.

9. Birthplace Elk Garden, W. Va.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Patrick J. Malloy

13. Birthplace Ireland

MOTHER 14. Maiden Name Mary Ann Flynn

15. Birthplace Ohio

16 (a) Informant Jas. E. Eckley

(b) Address 15 Lee St.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 13 1940 (month) (day) (year)

(c) Cemetery or crematory St Michaels

Location Frostburg Md.

18 (a) Funeral director Jacob Wise

(b) Address Frostburg, Md.

19 (a) 5-12-40 (Date rec'd by registrar) (b) Mrs. A. R. Fletcher Registrar

MEDICAL CERTIFICATION

20. Date of death 5/10/40 19___, at 2 20 M

21. I certify that death occurred on the date above stated; that I attended deceased from 3/25/40 19___, to 5/10/40 19___, and that I last saw HER alive on 5/10/40 19___.

Immediate cause of death	Duration
Pulmonary Tuberculosis	
Due to Pulmonary Infarction	
Due to	
Other conditions Chronic Myocarditis	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged ststistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. **Signature** Glen Kilday, M. D.
M. D. or other

Address 56 W. Main St Date signed 5/11/40

Frostburg Md.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-A)

CERTIFICATE OF DEATH

05027

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or insl. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 11 N. Grant

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Frank P. Eberly

3. (b) Social Security Number: None

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Pearl Eberly

6(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): Aug 22 - 1889

8. AGE: Years: 50 Months: 8 Days: 21 If less than one day: hrs. min.

9. Birthplace: Eckhart - Alley - Md.

(Town, county, and state)

10. Usual occupation: engineer

11. Industry or business: Post Office Bldg.

FATHER 12. Name: Joseph Eberly

13. Birthplace: U.S.

MOTHER 14. Maiden name: Mary Ann Canfield

15. Birthplace: England

16. Informant: Mrs Pearl Eberly

Address: Frostburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 16-1940 (month) (day) (year)

Cemetery or cemetery: St. Michaels

Location: Frostburg, Md

18. Funeral director: J. J. Durst

Address: Frostburg, Md.

19. 5 14 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13 1940, at 3:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13, 1940, to May 13 1940, and that I last saw him alive on May 13 1940.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	6 hrs
Due to: Hypertension	? ?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L. D. M. Lane Jr M.D. M. D. or other

Address: Frostburg Md Date signed May 14 40

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MAY 28 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

Mc Lane

05028 9

Reg. Dist. No.

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 133 Hill St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 133 Hill St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: George Eisel

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Sarah Eisel

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): August 10, 1868

8. AGE: Years: 72 Months: 9 Days: 2 If less than one day ____ hrs. ____ min.

9. Birthplace: Allegany Md.
(Town, county, and state)

10. Usual occupation: miner

11. Industry or business: Coal mines

FATHER
12. Name: George Eisel
13. Birthplace: Germany

MOTHER
14. Maiden name: Martha Baum
15. Birthplace: Germany

16. Informant: Mrs. George Hartig

Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 14-40 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg Md

18. Funeral director: J. J. Dierst

Address: Frostburg Md.

19. 5-14 (Date rec'd by registrar) 1940 Mrs A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 12 1940, at 6:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1939, to May 12 1940, and that I last saw him alive on May 11 1940.

Immediate cause of death: Chronic Myocarditis

Due to: —

Due to: —

Other conditions: —
(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy

DURATION: General years

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: W. O. McLane Jr. Md. M. D. or other

Address: Frostburg Md Date signed: May 13 '40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 3 1940
BUREAU V. S.

05029

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Alleghany

City or town Westernport (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 203 Vine Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 52 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Alleghany

City or town Westernport Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 203 Vine St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Susan Athalia Feehtig Engle

3. (b) Social Security Number

4. Sex: Female

5. Color or race: white

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Dr. Lewis Engle, Sr.

6(c) If alive, give age 81 years

7. Birth date of deceased (mo., day, yr.) Nov. 27, 1864

8. AGE: Years 76 | Months 6 | Days 25 | If less than one day ___ hrs. ___ min.

9. Birthplace Wellersburg, Somerset, Pa. (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Dr. Samuel Feehtig
13. Birthplace Cleaspring, Md.

MOTHER
14. Maiden name Mary Jane Winter
15. Birthplace Mt. Savage, Md.

16. Informant Mrs. Lucille Krantz

Address 203 Vine St. Westernport, Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof May 28-40 (month) (day) (year)

Cemetery or ~~crematory~~ ROSEHILL

Location CUMBERLAND, Md.

18. Funeral director W. H. Fredloch

Address Piedmont, W. Va

19. May 27 1940 (Date rec'd by registrar) A. J. Raymbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1940, at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1936, to May 25 1940, and that I last saw her alive on May 25 1940.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	2 weeks
Due to Hypertension and Arteriosclerosis	10 Years
Due to	
Other conditions Chronic Nephritis	4 Years

(Include pregnancy within 3 months of death)

Major findings:

Of operations None

Of autopsy None

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul R. Wilson, M.D. M. D. or other

Address Piedmont, W. Va Date signed 5-27-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

05030

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH (94a)

County Mines Hospital Registration Dist. No. 9

Village or City Frostburg Md No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds. (Reed 5-24-40)

2. FULL NAME Harman Durant Mathias Everline Soc. Sec. 214-05-9629

(a) Residence: No. 89 Washington St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Male	White	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth Wade Everline

6. DATE OF BIRTH (month, day, and year) Nov. 14-1900

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	6	4	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Rubber Worker

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Tire Manufacturing Co.

10. Date deceased last worked at this occupation (month and year) May 1940

11. Total time (years) spent in this occupation 16 yrs.

12. BIRTHPLACE (city or town) (State or country) Frostburg Md

FATHER

13. NAME Philip Everline

14. BIRTHPLACE (city or town) (State or country) Georges Mills Pa.

MOTHER

15. MAIDEN NAME Anna Wroll

16. BIRTHPLACE (city or town) (State or country) Frostburg Md.

17. INFORMANT Mrs. Harman Everline. (Address) 89 Washington St., Frostburg, Md.

18. BURIAL, ~~CREMATION, OR REMOVAL~~ Burial

Place Allegany Cemetery Date May 21, 1940

19. UNDERTAKER Jacob Hafer. (Address) Frostburg, Md

20. FILED 5-20, 1940 Mrs. A. R. Walker Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May 18 (Month) (Day) 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from May 18, 1940, to May 18, 1940

I last saw him alive on May 18, 1940; death is said to have occurred on the date stated above, at 9 P. m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Coronary occlusion	

Other **Contributory Causes** of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) A. M. Engle M. D.

(Address) Frostburg Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

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JUN 3 1949
BUREAU V. S.

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73a)

05031

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 20 N. Chase St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 20 N. Chase St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mrs. Ruth Flote

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	White	Widowed

6 (b) Name of husband or wife: Charles Floto

6(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Jan. 15, 1851

8. AGE: Years	Months	Days	If less than one day
89	3	29	____ hrs. ____ min.

9. Birthplace: Berlin, Penna.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: August Karol

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Hannah Kaiser

MOTHER — 15. Birthplace: Germany

16. Informant: Mrs. Wm. Frazee

Address: 20 N. Chase St. Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 17, 1940 (month) (day) (year)

Cemetery or crematory: I.O.O.F. Cem.

Location: Berlin, Penna.

18. Funeral director: J. C. Wolford

Address: Cumberland, Md.

19. May 16 19 40 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14, 19 40, at 4:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12, 19 40 to May 14, 19 40, and that I last saw h[illegible] alive on May 14, 19 40.

Immediate cause of death	DURATION
(a) Generalized Arteriosclerosis	2
Due to	
Due to	
Other conditions (b) Acute Myocarditis	10 Days

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 105 S. Centre St. Cumberland Md. Date signed: 5/15

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (8)

Reg. Dist. No. 4

05032

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town Cumberland
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Rear 20 Potomac St.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County Allegany
(c) City or town Cumberland
(If outside city or town limits, write RURAL and give town)
(d) Street No. Rear 20 Potomac St.
(If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Stillborn Frantz

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex xxx

5. Color or race White

6 (a) Single, married, widowed, or divorced. Single

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 14 1940

8. AGE: Years | Months | Days | If less than one day ____ hr. ____ min.

9. Birthplace Cumberland, Md. Allegany.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Donald W. Frantz
13. Birthplace Maryland.

MOTHER
14. Maiden Name Mary I. Hillegas
15. Birthplace Pennsylvania

16 (a) Informant Mary I. Frantz
(b) Address Cumberland, Md.

17 (a) (Burial, cremation, or removal) (b) Date thereof (month) (day) (year)
(c) Cemetery or crematory
Location Fortus

18 (a) Funeral director Castrone
(b) Address

19 (a) May 16, 1940 (Date rec'd by registrar) (b) J. P. Franklin M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 14 1940, at 4 A. M

21. I certify that death occurred on the date above stated; that I attended deceased from May 14 1940, to May 14 1940, and that I last saw him alive on 19.

Immediate cause of death | Duration

Due to Miscarriage

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature [illegible] M.D.
M. D. or other

Address Cumberland, Md. Date signed 5/16/40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

05033

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days): 3 Wks.

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: W. Va. County: Mineral

City or town: Keyser R.D. #1. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Short Gap
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: ✓

3. (a) FULL NAME: Mrs. Rozetta Catherine Grace

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Robert C. Grace

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Dec. 24, 1871

8. AGE: Years: 68 Months: 4 Days: 9 If less than one day: ____ hrs. ____ min.

9. Birthplace: West Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Jonathan Baker
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Julia Rice
15. Birthplace: W. Va.

16. Informant: Mrs. Julia Rowan

Address: Pasedina, Cal.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 5, 1940 (month) (day) (year)

Cemetery or crematory: Fort Ashby Cem.

Location: Fort Ashby, W. Va.

16. Funeral director: J. C. Wolford

Address: Cumberland, Md.

19. May 4 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3, 1940, at 325 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4-12-40 19__, to 4-3 1940, and that I last saw h[illegible] alive on 4-2-40 19__.

Immediate cause of death: Diabetes mellitus — ? DURATION
Cerebral Hemorrhage — 3 wks

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. Alfred Van Ormer M. D. or other

Address: Cumberland, Md. Date signed: 5-4-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3)

CERTIFICATE OF DEATH

05034

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Moscow
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Moscow Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby boy Greene

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 2, 1940

8. AGE:

Years	Months	Days	If less than one day
			hrs. min.

9. Birthplace Moscow, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Reynold Greene
13. Birthplace Moscow, Md.

MOTHER
14. Maiden name Stella Florella Robinette
15. Birthplace Corrigansville, Md.

16. Informant
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 2, 1940 (month) (day) (year)

Cemetery or crematory
Location

18. Funeral director None
Address

19. 19
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 19 40, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19, to 19,
and that I last saw h alive on 19.

Immediate cause of death stillborn — DURATION

Due to Prematurity - dead on arrival; absence of foot

Due to on right leg; also deformity of leg.

Other conditions
(Include pregnancy within 3 months of death)

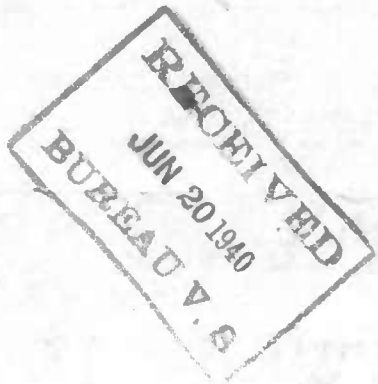
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Joseph Friedman M.D.
M. D. or other
Address Westernport, Md. Date signed 6-19-40

stillb.



WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (132)

CERTIFICATE OF DEATH

05035

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital Cumberland Md.
Stay in hospital or inst. (yrs., or mos., or days): 5 days
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: West Virginia County: Mineral
City or town: Keyser Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 112 Orchard St.
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR: ✓

3. (a) FULL NAME: Margaret Hailes

3. (b) Social Security Number: None

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Fremont Hailes
6(c) If alive, give age: 55 years
7. Birth date of deceased (mo., day, yr.): March 19, 1885
8. AGE: Years: 55 Months: 1 Days: 14 If less than one day: hrs. min.
9. Birthplace: Steubenville, Ohio (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Michael O'Brian
13. Birthplace: Ireland
MOTHER 14. Maiden name: Unknown
15. Birthplace:
16. Informant: Fremont Hailes
Address: 112 Orchard St. Keyser, W. Va
17. Removal (Burial, cremation, or removal. Which?) Date thereof May 4, 1940 (month) (day) (year)
Cemetery or crematory: Steubenville Cem.
Location: Steubenville, Ohio
18. Funeral director: Louis Stein, Inc
Address: Cumberland, Md
19. May 4, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3rd 1940, at M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 29, 1940, to May 3, 1940, and that I last saw h alive on May 3, 1940.

	DURATION
Immediate cause of death: Auricular Fibrillation	5 days
Due to: Primary cause of the acute mia? Embarrassment w.p.w.	
Due to: Duration's research months	
Other conditions: Acute Anemia	2 days

(Include pregnancy within 3 months of death)

Major findings:
Of operations: None
Of autopsy: None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Cumberland Md. Date signed 5-4-40

RECEIVED
JUN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05036

Reg. Diat. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Reeves Clinic

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: W. Va. County: Mineral

City or town: Rural-Keyser Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. R#3
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Verna Susan Harman

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

8 (b) Name of husband or wife: Orie Abraham Harman

6(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): March 11, 1892

8. AGE:

Years	Months	Days	If less than one day
48	2	4	____ hrs. ____ min.

9. Birthplace: Kline, Pendleton Co. W. Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Solomon Greenamalt
13. Birthplace: Kline, W. Va.

MOTHER
14. Maiden name: Susan Hinkle
15. Birthplace: Unknown

16. Informant: O. A. Harman
Address: Keyser, R#3 W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 18, 1940 (month) (day) (year)

Cemetery or crematory: Hedon Point Cemetery

Location: Keyser, W. Va.

18. Funeral director: H. H. Rogers

Address: Keyser, W. Va.

19. May 17 1940 (Date rec'd by registrar) O. J. Baynbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15, 1940, at 8:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 21 1940, to May 15 1940, and that I last saw h alive on May 15 1940.

Immediate cause of death: Chronic Nephritis — DURATION: 7

Due to: Hypertension

Due to: Chr myocarditis

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L. W. Reeves M.D.
M. D. or other

Address: Westernport Md Date signed 5/17/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 5 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33-a)

CERTIFICATE OF DEATH

05037

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or insl. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 56 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No.: 308 Paca St. (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME Wm.
Mr. George Hast

3. (b) Social Security Number 214-05-4696

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 10 1884

8. AGE: Years	Months	Days	If less than one day
56	—	1	hrs. min.

9. Birthplace: Cumberland Maryland (Town, county, and state)
10. Usual occupation: Clerk (Retired)
11. Industry or business: Kuirich and Jenkins Clothiers
FATHER 12. Name: Frederick Hast
FATHER 13. Birthplace: Cumberland Md
MOTHER 14. Maiden name: Sophia Lochner
MOTHER 15. Birthplace: Scotland Cumberland Md
16. Informant: Julius Hast
Address: Cumberland.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 14 40 (month) (day) (year)
Cemetery or crematory: St Louis Cem.
Location: Cumberland
18. Funeral director: Louis Stein Inc
Address: Cumberland
19. May 13 1940 (Date rec'd by registrar) J. P. Buckler, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11 1940, at 1:40 A. M.
21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from 5-10- 1940, to 5. 11. 1940 and that I last saw him alive on 5. 10. 1940.

Immediate cause of death	DURATION
Pneumonia (Influenza)	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed 5-11-40

Williams

Dr F. Williams

RECEIVED
MAY 14 1940
BUREAU V.S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83rd)

CERTIFICATE OF DEATH

05038

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 227 Fayette st
Stay in hospital or insf. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 50 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.: (If outside city or town limits, write RURAL NEAR and give town)
Street No.: 227 Fayette (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: John Louis Heintz

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Katherine Pfeiffer
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 31 1856

8. AGE: Years	Months	Days	If less than one day
83	8	15	hrs. min.

9. Birthplace: Frostburg Md (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Restaurant

FATHER
12. Name: Charles Heintz
13. Birthplace: Alsace Lorraine France

MOTHER
14. Maiden name: Elizabeth Opth
15. Birthplace: Hesse Castle Germany

16. Informant: Mrs Geo Barker
Address: 811 Fayette St City

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 18/40 (month) (day) (year)
Cemetery or crematory: Rose Hill Mausoleum
Location: Cumberland Md

18. Funeral director: Wm H. Kight
Address: Cumberland Md

19. May 17 1940 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 1940, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13 1940, to May 16 1940 and that I last saw him alive on May 15 1940

Immediate cause of death: Cerebral Hemorrhage — DURATION: 5/13/40
Due to: Cerebral Arteriosclerosis — ?
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work? —

23. SIGNATURE: W. Royce Hodges, M.D.
Address: Cumberland, Md M. D. or other
Date signed: 5/16/40

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

CERTIFICATE OF DEATH

05039 —

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital Decatur St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Penna. County Bedford

City or town Buffalo Mills R.D.I. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Girl Hendershot

3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Stillborn - May 25, 1940

8. AGE: Years | Months | Days | If less than one day hrs. min.

9. Birthplace Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Robert Hendershot

13. Birthplace Afton Ohio.

MOTHER 14. Maiden name Lillian Snyder

15. Birthplace Paw Paw, W. Va.

16. Informant Robert Hendershot

Address Buffalo Mills Pa. R.D.I.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 25, 1940 (month) (day) (year)

Cemetery or crematory Madley Cemetery

Location Madley Pa.

18. Funeral director Harvey H. Zeigler

Address Hyndman, Pa.

19. May 25, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1940, at 6 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 25 1940, to May 25 1940, and that I last saw h SR dead on May 25 1940.

Immediate cause of death	DURATION
Still Born Female Infant (Premature 7 mo. Gestation)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A. Topper M.D.
M. D. or other

Address Hyndman Pa. Date signed 5/25/40

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

05040

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days) 4 days
Stay in this community (yrs., or mos., or days) 48 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 187 Thomas Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME LEE
VIRGIE HENRY

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife Arthur Henry
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) January 30 1882

8. AGE: Years 58 | Months 3 | Days 7 | If less than one day ____ hrs. ____ min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER
12. Name Thomas Kelly
13. Birthplace Maryland

MOTHER
14. Maiden name Clara Judy
15. Birthplace Maryland

16. Informant Mrs. Hope Allen
Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 10, '40 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.
Location Cumberland

18. Funeral director Louis Stein Inc
Address Cumberland

19. May 9 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-7-1940, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-3-1940 to 5-7-1940; and that I last saw her alive on 5-7-1940

Immediate cause of death	DURATION
Cerebral Thrombosis	3 wks.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations None
Of autopsy None

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE Wm. X. Williams M. D. or other
Address Cumberland Date signed 5-8-40

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

05041

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a) R CB

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 15 S. Waverly Terrace

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: District of Columbia County:

City or town: Washington Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1820 - 19th St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: World War

3. (a) FULL NAME: Ralph W. Hills

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Mary E Gorman

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June 7 1875

8. AGE: Years: 64 Months: 11 Days: 14 If less than one day ____ hrs. ____ min.

9. Birthplace: Cleveland Ohio
(Town, county, and state)

10. Usual occupation: Writer

11. Industry or business: Books

FATHER
12. Name: Charles W. Hills
13. Birthplace: Cleveland Ohio

MOTHER
14. Maiden name: Sarah McConnell
15. Birthplace: Cleveland Ohio

16. Informant: Dr Ralph Hills

Address: Baltimore Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof: May 23 1940 (month) (day) (year)

Cemetery or crematory: Washington DC

Location: Washington DC

18. Funeral director: Louis Stein Inc

Address: Cumberland Md

19. May 22 1940 (Date rec'd by registrar) J. P. Franklin, M.A. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21st., 1940, about 4.30 A. at ____ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h____ alive on ____ 19__.

Immediate cause of death: Coronary Thrombosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations: none

Of autopsy: none

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Lynne H. Corson, M.D. M. D. or other

Address: Cumberland, Md. Date signed: 5/21/40

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 6 1940
BUREAU V. S.

Outside of City limits

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (82) Reg. Dist. No. 4

CERTIFICATE OF DEATH

05042

1. PLACE OF DEATH:
(a) County Allegany
(b) City or town R.D. #2. Cumberland
(If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: R.D.#2 Cumberland
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Allegany
(c) City or town R.D.#2. Cumberland
(If outside city or town limits, write RURAL and give town)
(d) Street No.
(If rural give locstion)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Agnes O. Hoffman

3 (b) If veteran, name war: no
3 (c) Social Security No. None

4. Sex: Female
5. Color or race: White
6 (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Thomas Hoffman
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 2, 1863

8. AGE: Years 76 | Months 7 | Days 13 | If less than one day hr. min.

9. Birthplace Beans Cove, Penna.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name Elijah Casteel
13. Birthplace Penna.

MOTHER
14. Maiden Name Priscella Ruby
15. Birthplace Penna.

16 (a) Informant Thomas Hoffman
(b) Address R.D.#2. Cumberland, Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 17.1940 (month) (day) (year)
(c) Cemetery or crematory Mt. Pleasant Cem.
Location Balti. Pike

18 (a) Funeral director J. C. Wolford
(b) Address Cumberland, Md.

19 (a) May 17 1940 (Dste recd by registrar) (b) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 15, 1940, at 5.45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from Dec 13 1939, to May 15 1940, and that I last saw him alive on May 13 1940.

Immediate cause of death Sclerosis Spinal cord — Duration
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Eugene Kester M. D. or other
Address Bedford Valley Rt Date signed May 17 40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

Kentucky

RECEIVED
JUN 6 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-0)

CERTIFICATE OF DEATH

05043

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Jackson Street
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 25 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Lonaconing Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Thomas Francis Hughes Sr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Bessie Hughes
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 15. 1868

8. AGE: Years	Months	Days	If less than one day
71	8	19	hrs. min.

9. Birthplace: Ireland (Town, county, and state)
10. Usual occupation: Miner
11. Industry or business: Coal Mine
FATHER 12. Name: Thomas Hughes
13. Birthplace: Ireland
MOTHER 14. Maiden name: not Known
15. Birthplace: Ireland
16. Informant: Fredrick F. Hughes
Address: Jackson St. Lonaconing. Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 7. 1940 (month) (day) (year)
Cemetery or crematory: St. Marys.
Location: Lonaconing Md.
18. Funeral director: D. S. Boal.
Address: Lonaconing, Md.
19. May 7 1940 (Date rec'd by registrar) E. Dan Taylor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 1940, at 3:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1940, to May 4 1940, and that I last saw h alive on May 4 1940.

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D.
M. D. or other
Address: Lonaconing, Md. Date signed: May 6' 40

RECEIVED
JUN 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (182)

05044

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:

County: allegany

City or town: Mt Savage
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or insf. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: allegany

City or town: Mt Savage Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Edward Hutzell

3. (b) Social Security Number

4. Sex: M

5. Color or race: W

6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Dec 17-1939

8. AGE: Years: — Months: 4 Days: 17 If less than one day: hrs. min.

9. Birthplace: Mt Savage - alleg. Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Ralph Hutzell
13. Birthplace: Mt Savage Md.

MOTHER
14. Maiden name: Sara Tinley
15. Birthplace: Goldsborough Md.

16. Informant: Ralph Hutzell
Address: Mt Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 6-1940 (month) (day) (year)

Cemetery or crematory: Methodist

Location: Mt. Savage, Md.

18. Funeral director: J. J. Durst
Address: Frostburg, Md.

19. May 6th 1940 (Date rec'd by registrar) H. J. Bostetter M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4th., 1940, at about 12.45 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19, and that I last saw h alive on 19.

Immediate cause of death: Accidental Suffocation during sleep.

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations: none

Of autopsy: none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 5/4/40

Where did injury occur? Mt. Savage, Allegany, Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): home

Means of injury: suffocation Injured at work? no

23. SIGNATURE: Pierce H. Corson, M.D.
M. D. or other

Address: Cumberland, Maryland. Date signed: 5/4/40

Deputy Medical Examiner - Allegany Co.

RECEIVED
JUN 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(97)

05045

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 47 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 320 CRAWFORD ST.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME JACOBS, COLEMAN JOHN

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6 (b) Name of husband or wife CRISTMORE, ALLIE

DECEASED 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 1, 1849

8. AGE: Years	Months	Days	If less than one day
90	8	14	hrs. min.

9. Birthplace PENNA.
(Town, county, and state)

10. Usual occupation UNABLE TO WORK

11. Industry or business

FATHER
12. Name JACOBS, JOHN
13. Birthplace Coatesville, Pa.

MOTHER
14. Maiden name Eliza Williamson
15. Birthplace Coatesville, Pa.

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 18, 1940 (month) (day) (year)

Cemetery or crematory Mt. Hebron Cemetery

Location Winchester, Va.

18. Funeral director Jacob Hofer

Address 230 Baltimore Ave.

19. May 17, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. GROVE

MEDICAL CERTIFICATION

2:10 PM

20. DATE OF DEATH MAY 15, 1940, at M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from May 29 1940, to May 15, 1940, and that I last saw him alive on May 15, 1940.

Immediate cause of death: Senile gangrene of left leg.

Due to Arterial sclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Dt operations Infection in small bones of foot

Dt autopsy none

DURATION: 2 mos

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. B. Moore M.D. M. D. or other

Address Medical Bldg Date signed 5/16/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M)

(T)

RECEIVED
JUN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

WITHIN CORPORATE LIMITS

127-a

CERTIFICATE OF DEATH

Reg. Dist. No. 05048

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days): 11 days

Stay in this community (yrs., or mos., or days): 42 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 60 Linden St.,
(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Elizabeth Thomas Jennings

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife: Wm. Jennings

(c) If alive, give age: 50 years

7. Birth date of deceased (mo., day, yr.): April 29, 1898

8. AGE:

Years	Months	Days	If less than one day
42		17	hrs. min.

9. Birthplace: Frostburg Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Wm. R. Thomas
13. Birthplace: Maryland

MOTHER
14. Maiden name: Nancy A. Workman
15. Birthplace: Maryland

16. Informant: Wm. Jennings,
Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 19, 1940 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg Md.

18. Funeral director: J. J. Durst,

Address: Frostburg, Md.

19. 5-19- 1940 (Date rec'd by registrar) mrs. A. F. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 16 1940 at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1940 to May 17 1940 and that I last saw her alive on May 16 1940

	DURATION
Immediate cause of death: Pulmonary Embolus	
Due to: Part of Scalp	
Due to:	
Other conditions: Chronic nephritis Diabetes mellitus	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: A. M. Earle M.D. or other

Address: Frostburg Md. Date signed: 5-19-40

RECEIVED
JUN 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-a)

CERTIFICATE OF DEATH

05047

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Railroad Street

Stay in hospital or inst. (yrs., or mos., or days): 2

Stay in this community (yrs., or mos., or days): 62-1-9

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Railroad
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: X

3. (a) FULL NAME: James Kirkwood Jones

3. (b) Social Security Number: 220-10-2195

4. Sex: Male | 5. Color or race: White | 6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Amelia Lyons Jones

6(c) If alive, give age: 58 years

7. Birth date of deceased (mo., day, yr.): April 7th 1878

8. AGE: Years: 62 | Months: 1 | Days: 9 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Lonaconing Allegany Co. Md
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Savage River Dam

FATHER
12. Name: Daniel P. Jones
13. Birthplace: Nova Scotia

MOTHER
14. Maiden name: Jean Kirkwood
15. Birthplace: Eckhart, Md

16. Informant: Kirkwood Jones
Address: Finzel, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 18 1940 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md.

18. Funeral director: W. Eichhorn

Address: Lonaconing Md.

19. May 17 1940 E. Dorothy Cox
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15 1940, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19____, to ____ 19____, and that I last saw h[illegible] alive on May 15 1940.

	DURATION
Immediate cause of death: Coronary occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: Henry M. Hodgson M D.
M. D. or other

Address: Lonaconing, Md. Date signed May 18 1940

RECEIVED
JUN 5 1940
BUREAU V. S.

05048

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-6)

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:

County Allegany

City or town Mt Savage (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 56 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Allegany

City or town Mt Savage Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Mary Joseph Kenney

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb. 23, 1884.

8. AGE: Years 56 | Months 2 | Days 3 | If less than one day hrs. min.

9. Birthplace Barton Allegany Co. Md. (Town, county, and state)

10. Usual occupation House work

11. Industry or business Own Home

FATHER 12. Name Edward Kenney

13. Birthplace Barton Md

MOTHER 14. Maiden name Mary Ann Conroy

15. Birthplace Barton Md

16. Informant Timothy Kenney

Address Mt Savage Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 9 1940 (month) (day) (year)

Cemetery or crematory St Patricks.

Location Mt Savage Md.

18. Funeral director Louis Stein Inc.

Address Cumberland Md.

19. 5/7 1940 H J Bostetter M.D. Local Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 1940, at 8.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 5 1940, to May 6 1940, and that I last saw her alive on May 6 1940.

Immediate cause of death Cerebral Hemorrhage — DURATION 3 days

Due to Hypertension

Due to Chronic Nephritis — 7 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Dt operations

Dt autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H J Bostetter M.D. M. D. or other

Address Mt Savage Md Date signed 5/7-40

VS A15 (T) (I) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

05049

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170-a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or insf. (yrs., or mos., or days): 1 hr.

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: North Front St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Samuel E Landis

3. (b) Social Security Number: None.

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Bessie Boston

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): March, 1878

8. AGE: Years 62 Months 2 Days ____ If less than one day ____ hrs. ____ min.

9. Birthplace: Port Royal, Penna
(Town, county, and state)

10. Usual occupation: Cabinet maker

11. Industry or business: Own self

FATHER
12. Name: William Henry Landis
13. Birthplace: Pa

MOTHER
14. Maiden name: Mary Marie Eichman
15. Birthplace: Pa

16. Informant: Mr Myron Landis

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 1 40 (month) (day) (year)

Cemetery or crematory: Hillcrest

Location: Cumberland Md

18. Funeral director: Louis Stein Inc.

Address: Cumberland Md

19. June 1, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29th 1940, at 11.35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h____ alive on ____ 19__.

Immediate cause of death: brushed chest (R.R. crossing accident)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations: none

Of autopsy: none

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 5/29/1940

Where did injury occur? Cumberland (City or town), Allegany (County), Md. (State)

Injured at home, farm, industry, public place (where?): R.R. crossing

Means of injury: Struck by train Injured at work? no

23. SIGNATURE: Linnie H. Corson, M.D. M. D. or other

Address: Cumberland, Md. Date signed: 5-30-'40

Deputy Medical Examiner - Allegany Co.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1940
U. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

05050

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:
MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 18 Days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town MT. LAKE PARK, Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME MRS. ALTHEA LEE

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6 (b) Name of husband or wife MELVIN E. LEE

6(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) MAR. 1, 1889

8. AGE: Years	Months	Days	If less than one day
50	2	5	hrs. min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name AMOS BITTINGER
13. Birthplace MARYLAND

MOTHER
14. Maiden name ELIZABETH BRENNEMAN
15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 8, 1940 (month) (day) (year)

Cemetery or crematory Pleasant Valley

Location 2 Mi. So. out. Lake Park, Md.

18. Funeral director Herbert C. Leichliter

Address Oakland, Md.

19. May 6 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 6, 1940 9:20 a.m. P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 18 1940, to May 6 1940, and that I last saw h[illegible] alive on May 5 1940.

Immediate cause of death Carcinomatosis

DURATION 2 4 days

Due to (Operated) Perforated gastric ulcer

Due to Primary adeno Carcinoma

Other conditions Breast removed 2-6-40

(Include pregnancy within 3 months of death)

Major findings: Perforated gastric ulcer
Of operations Carcinomatosis

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. M. Wilson M.D.
M. D., or other

Address Cumberland Md Date signed 5-6-40

DR. F. WILSON

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(94a)

05051

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Frostburg - Borden Miners Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: John Edward Lyons

3. (b) Social Security Number: 219-03-8015

4. Sex: M

5. Color or race: W

6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife: —

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): March 7 - 1896

8. AGE: Years: 44 Months: 2 Days: 10 If less than one day ____ hrs. ____ min.

9. Birthplace: Frostburg - Alleg - Md. (Town, county, and state)

10. Usual occupation: Coal miner

11. Industry or business: Mining coal

FATHER

12. Name: Michael Lyons

13. Birthplace: Eckhart, Md.

MOTHER

14. Maiden name: Jennet Gordon

15. Birthplace: Scotland

16. Informant: Mrs Robert Brown

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 20-1940 (month) (day) (year)

Cemetery or ~~cremator~~: Allegany

Location: Frostburg, Md

18. Funeral director: J J Dwyer

Address: Frostburg, Md

19. 5-19 (Date rec'd by registrar) 1940 Mrs. A. R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 1940 at 6A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1940, to May 17 1940, and that I last saw him alive on May 17 1940.

Immediate cause of death: Coronary occlusion

DURATION

~~Due to~~ Asthma

~~Due to~~ Congestive Heart failure

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: A M Earle M. D. or other

Address: Frostburg Md Date signed: 5-18-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M) (I) (T)

RECEIVED
JUN 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-E)

CERTIFICATE OF DEATH

05052

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: ~~Baltimore~~ - Near Dawson, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: ~~Baltimore~~ Near Dawson, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Flora Emily Maine

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife: Ray William Maine

6(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Aug. 20, 1883

8. AGE: Years: 50 | Months: 9 | Days: | If less than one day: hrs. min.

9. Birthplace: Mineral Co. W. Va.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: Nicholas Biser
13. Birthplace: Hampshire Co. Virginia

MOTHER
14. Maiden name: Martha Jane Featherman
15. Birthplace: Hampshire Co. Virginia

16. Informant: Ray M. Maine
Address: Rawlings, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 23, 1940 (month) (day) (year)

Cemetery or crematory: Queenspoint

Location: Keyser, Mineral Co. W. Va.

18. Funeral director: H. H. Rogers

Address: Keyser, W. Va.

19. May 23 19 40 (Date rec'd by registrar) J. Baynhaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20, 1940, at 2:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 40, to May 15, 19 40, and that I last saw her alive on May 15, 19 40.

Immediate cause of death: Carcinamatosis — DURATION: 1 yr.

Due to: Carcinoma of Uterus.

Due to:

Other conditions: Myocarditis

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Thad T. Huffman, M.D.
M. D. or other

Address: Keyser, W. Va. Date signed: 5-23-40

RECEIVED
JUN 5 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (136a)

CERTIFICATE OF DEATH

05053

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: MEMORIAL HOSPITAL
Stay in hospital or Inst. (yrs., or mos., or days) 12 DAYS
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND, MARYLAND Ward No. (If outside city or town limits, write RURAL NEAR and give town)
Street No. 638 COLUMBIA AVE (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME ANDREW MARTIN MR.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6 (b) Name of husband or wife EUNICE ~~Humberston~~ Robertson
6(c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) MAY 10, 1871

8. AGE: Years	Months	Days	If less than one day
69	0	10	hrs. min.

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation BALTIMORE AND OHIO RAILROAD
11. Industry or business Watchman
FATHER 12. Name PHILLIP C. MARTIN
13. Birthplace PA
MOTHER 14. Maiden name ARNOLD, ——
15. Birthplace MD.
16. Informant Memorial Hosp. Address Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 23, 1940 (month) (day) (year)
Cemetery or crematory St. Patrick's Cem
Location Cumberland, Md.
18. Funeral director L. Lemperenr
Address Cumberland, Md
19. May 23, 1940 (Date rec'd by registrar) J.P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION @4:05 P.M.

20. DATE OF DEATH MAY 20 1940, at P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-8- 1940 to 5-20- 1940, and that I last saw h Im alive on 5-20- 1940.

	DURATION
Immediate cause of death: Myocardial degeneration	?
Due to Chronic pyelonephritis	?
Due to	
Other conditions Multiple urethral structures	

(Include pregnancy within 3 months of death)

Major findings:
Of operations Complete urinary retention relieved by Cystotomy 5-9-40
Of autopsy

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Howard L. Falcon M. D., or other
Address Cumberland, Md. Date signed
DR. ROZUM

RECEIVED
JUN 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

05054

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (121)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 2 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Washington

City or town Hancock Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME May Pearl Mason

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~ Willis Freeman Mason

6(c) If alive, give age 40 years

7. Birth date of deceased (mo., day, yr.) May 10, 1896

8. AGE: Years 44 Months 0 Days 20 If less than one day ___ hrs. ___ min.

9. Birthplace Fulton County ~~Maryla~~ Pa.
(Town, county, and state)

10. Usual occupation House Wife

11. Industry or business

FATHER
12. Name Unknown
13. Birthplace

MOTHER
14. Maiden name Lydia Mann
15. Birthplace Fulton Pa.

16. Informant William Freeman Mason
Address Hancock, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 2, 1940 (month) (day) (year)

Cemetery or crematory May Chapel, Cem

Location Near Warfordsburg, Penna.

18. Funeral director Snyder & Rowland
Address Hancock Maryland

19. May 31, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 30 1940, at 5:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29 1940, to May 30 1940, and that I last saw her alive on May 30 1940.

Immediate cause of death: Acute Gangrenous Appendicitis — DURATION: 2 dys

Due to

Due to

Other conditions: General Peritonitis — 2 dys
(Include pregnancy within 3 months of death)

Major findings:
Of operations: Acute Gangrenous Appendicitis. General Peritonitis
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T. Johnson Jr. M. D. or other

Address Cumberland, Md Date signed 5-30-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1940
BUREAU V. S.

05055

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany

City or town Western Port.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 141 Church

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Westernport Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 141 Church St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Patrick F. McDonald

3. (b) Social Security Number NONE

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 1845

8. AGE: Years 84 | Months | Days | If less than one day hrs. min.

9. Birthplace Westernport, Allegany Md
(Town, county, and state)

10. Usual occupation Retired Boilermaker

11. Industry or business

FATHER
12. Name Don't Know.
13. Birthplace

MOTHER
14. Maiden name Don't Know.
15. Birthplace

16. Informant Mr. E. J. Noon

Address Westernport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 3 1940 (month) (day) (year)

Cemetery or crematory St. Peters cemetery

Location Westernport Md

18. Funeral director W. H. Fredlock

Address Piedmont W. Va.

19. June 1 1940 (Date rec'd by registrar) A. J. Gaynbaker M. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1940, at 2:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1 1934, to May 31 1940, and that I last saw him alive on May 31 1940.

Immediate cause of death	DURATION
acute myocarditis	5 days
Due to arteriosclerosis	1930
Slight Cerebral hemorrhage	May 2-1940
Due to	
Other conditions Epithelioma Back of L. Hand	1934

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide No Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE P E Berry M.D. M. D. or other

Address Piedmont W. Va Date signed 6/1/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
JUN 5 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

05056

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 15 S. Allegany St

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 50 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 15 S. Allegany
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Catherine McKay

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Frank H. McKay

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Apr 24 - 1858

8. AGE: Years 82 | Months — | Days 11 | If less than one day ____ hrs. ____ min.

9. Birthplace: Jefferson Co. W. Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Robert H Butcher
13. Birthplace: Va.

MOTHER
14. Maiden name: Virginia Opie
15. Birthplace: Va.

16. Informant: Dan McKay

Address: Cumberland

17. Burial (Burial, cremation, or remo... Which?) Date thereof May 7 40 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. May 7 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-5-40 1938, at P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 8, 1939, to 5-5-1940 and that I last saw her alive on 5-5-40 19__.

Immediate cause of death: Acute Myocarditis

Due to —

Due to age

Other conditions —

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION: 10 Days

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of Injury ____ Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Cumberland Md Date signed 5-7-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-d)

CERTIFICATE OF DEATH

05057

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 307 Holland St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 59 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 307 Holland
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Thomas A. Metz

3. (b) Social Security Number 205-05-8556

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

B (b) Name of husband or wife Dollie Howerth
6(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) August 14 1880

8. AGE: Years 59 | Months 9 | Days 9 | If less than one day ____ hrs. ____ min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Car Repairman

11. Industry or business B & O Ry.

FATHER 12. Name Wm. Metz
13. Birthplace Md.

MOTHER 14. Maiden name Elizabeth Gephart
15. Birthplace Md.

16. Informant Mrs. Dollie Metz
Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 26 1940 (month) (day) (year)
Cemetery or crematory Rose Hill Cem.
Location Cumberland Md

18. Funeral director Louis Stein Sons
Address Cumberland Md

19 May 24 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 23 1940, at 1¼ P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 1940, to May 23 1940, and that I last saw him alive on May 20 1940.

	DURATION
Immediate cause of death Exhaustion, Cancer	
Due to Carcinoma R Lung	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations Carcinoma R Lung
Biopsy at Spec I Jan 40
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE F. Alan G. Lamplugh M. D. or other
Address 41 Exchange St Cumberland Date signed May 23 40

RECEIVED
JUN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-d)

CERTIFICATE OF DEATH

03058

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 47 Mt. Pleasant St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg Ward No. Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 47 Mt. Pleasant
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Jane Rebecca Miller

3. (b) Social Security Number: none

4. Sex: F

5. Color or race: W

6. (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Wm Miller

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 5 — 1860

8. AGE: Years: 79 Months: 5 Days: 12 If less than one day: hrs. min.

9. Birthplace: Eckhart-alley-md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Wm Lewis

13. Birthplace: Wales

MOTHER 14. Maiden name: Sarah A. Price

15. Birthplace: Wales

16. Informant: Elmer Miller

Address: Frostburg, md

17. burial (Burial, cremation, or removal. Which?) Date thereof: May 19-1940 (month) (day) (year)

Cemetery or crematory: Eckhart

Location: Eckhart, md

18. Funeral director: J. J. Dunn

Address: Frostburg, md

19. May 19 1940 (Date rec'd by registrar) Mrs. A.R. Walker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 17 1940, at 10 00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 1940 to May 17 1940, and that I last saw h-er alive on May 16 1940

	DURATION
Immediate cause of death: Chr Myocarditis	?
Due to: acute Cholecystitis	1 day
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W.O. McLane M.D. M. D. or other

Address: Frostburg Md Date signed: May 17 1940

RECEIVED
JUN 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-P)

CERTIFICATE OF DEATH

05059

Reg. Diat. No. 10

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegheny
City or town Mt Savage Road
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 25 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegheny
City or town Mt Savage Road Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Morgan David Morgan Sr.

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife Jennie E. Morgan
6(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) December 3 1869

8. AGE: Years	Months	Days	If less than one day
71	5	~~X~~8	hrs. min.

9. Birthplace Morris Run Penna
(Town, county, and state)
10. Usual occupation Mine Foreman
11. Industry or business
FATHER 12. Name John Morgan
13. Birthplace Wales
MOTHER 14. Maiden name Mary Richards
15. Birthplace Wales
16. Informant Robert Klosterman
Address Mt Savage Road
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 13. 1940 (month) (day) (year)
Cemetery or crematory Methodist Cemetery
Location Mt Savage Md
18. Funeral director C. L. Kemperman
Address Cumberland Md
19. May 12 1940 H. J. Bostetter M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1940, at 3:45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6 1940, to May 11 1940 and that I last saw him alive on May 9 1940.

	DURATION
Immediate cause of death Uremia	6 days
Due to Chronic Nephritis	2
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. J. Bostetter M.D.
M. D. or other
Address Mt Savage Md Date signed 5/12/40

RECEIVED
JUN 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05060

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) 1 wk

Stay in this community (yrs., or mos., or days) 20 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward (No.) (If outside city or town limits, write RURAL NEAR and give town)

Street No. Route #3 (If rural, give LOCATION)

2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME Harry Oran Morris

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Laura Thorn Morris

6(c) If alive, give age 52 years

7. Birth date of deceased (mo., day, yr.) May 19 1874

8. AGE: Years 65 | Months 11 | Days 29 | If less than one day ____ hrs. ____ min.

9. Birthplace Muncie Ind (Town, county, and state)

10. Usual occupation Glass gatherer

11. Industry or business Glass factory

FATHER 12. Name Albert Bishop

FATHER 13. Birthplace Muncie Ind.

MOTHER 14. Maiden name Hannah Girgid

MOTHER 15. Birthplace Muncie Ind

16. Informant Laura Morris

Address Route #3 Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20 1940 (month) (day) (year)

Cemetery or crematory Zion Cem

Location Cumberland Md

18. Funeral director Jacob Dafey

Address Cumberland

19. May 20 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-18-40 19 9.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-15-40 19 ____, to ____ 19 ____, and that I last saw him alive on 5-18-40 19 ____.

Immediate cause of death Coronary occlusion — DURATION 1 day

Due to —

Due to —

Other conditions Uremia — 3

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. Lamm M.D. M. D. or other

Address Cumberland Md Date signed 5-20-40

RECEIVED
JUN 6 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

05061

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH (93-d)

County Allegany — Registration Dist. No. 9

Village or City Frostburg — No. 13 High St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Laura Eliza Hamill Myers

(a) Residence: No. 13 High St., Ward.

(Usual place of abode) — If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Widowed.

5a. If married, widowed, or divorced — HUSBAND of (or) WIFE of: Andrew Myers

6. DATE OF BIRTH (month, day, and year): March 12, 1865.

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	2	5	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Housework

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: at Home

10. Date deceased last worked at this occupation (month and year): Nov 1939.

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Jockey Hollow Va.

FATHER

13. NAME: Lewis Hamill

14. BIRTHPLACE (city or town) (State or country): " "

MOTHER

15. MAIDEN NAME: Laura Cleary

16. BIRTHPLACE (city or town) (State or country): " "

17. INFORMANT: Andrew Fuller (Address) 13 High St Frostburg md

18. BURIAL, CREMATION, OR REMOVAL: Place Allegany Cemetery Date May 20, 1940

19. UNDERTAKER: Jacob Hafer 2nd (Address) Frostburg Md

20. FILED 5-20, 1940 Miss A. R. Archer Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May (Month) 17 (Day), 1940 (Year).

22. I HEREBY CERTIFY, That I attended deceased from June 1, 1938, to May 17, 1940

I last saw her alive on May 17, 1940; death is said to have occurred on the date stated above, at 8:40 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Chronic myocarditis	5 yrs.
Chronic cholecystitis.	10 yrs.

Other Contributory Causes of importance:

arterio - sclerosis.	

Name of operation: Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of Injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) H. C. Diehl M. D.

(Address) Frostburg, Md.

Dr Diehl.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED JUN 3 1940 BUREAU

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

05062

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:

County: allegany

City or town: Mt Savage - R.F.D. Slabtown (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: allegany

City or town: Mt Savage - rural Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: Slabtown (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Raphael Principe

3. (b) Social Security Number: None

4. Sex: ♂

5. Color or race: w

6. (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife: Louis Principe

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June 6 — 1852

8. AGE: Years: 87 Months: 10 Days: 28 If less than one day ____ hrs. ____ min.

9. Birthplace: Italy (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER 12. Name: unknown

13. Birthplace: Italy

MOTHER 14. Maiden name: unknown

15. Birthplace: Italy

16. Informant: Michael Bishields

Address: Mt. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 7-1940 (month) (day) (year)

Cemetery or crematory: St Patricks

Location: Mt. Savage

18. Funeral director: J. J. Durst

Address: Frostburg, Md.

19. 5/6 1940 (Date rec'd by registrar) H. C. Bostetter MD Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3 1940 at 10 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1940 to May 4 1940 and that I last saw her alive on May 4 1940

Immediate cause of death: Bronchopneumonia

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: C. McEach M. D. or other

Address: Cowrunions Frostburg Date signed May 4 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-a)

CERTIFICATE OF DEATH

05063

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 744 Baker St

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 744 Baker St

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Mrs Hulda R. Pugh

3. (b) Social Security Number: —

4. Sex: F

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband ~~or wife~~: Walter Pugh

6(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): Nov 6 - 1875

8. AGE: Years: 64 Months: 5 Days: 19 If less than one day: ____ hrs. ____ min.

9. Birthplace: Penna (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: —

FATHER 12. Name: August Hoto

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Roseanna Zorn

MOTHER 15. Birthplace: Penna

16. Informant: Mrs Walter Pugh

Address: Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 15/40 (month) (day) (year)

Cemetery or crematory: Union Cemetery

Location: Myersdale, Pa

18. Funeral director: U. L. Lamberson

Address: Cumberland, Md.

19. May 14 19 40 J. L. Franklin, M.D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/12/40 19 ____, at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/15/40 19 ____, to 5/12/40 19 ____, and that I last saw h- alive on 5/12/40 19 ____.

Immediate cause of death: Carcinoma of Cervix — DURATION

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy: —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: —— Date of: ——

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ——

Means of injury: —— Injured at work?

23. SIGNATURE: Richard J. Williams M.D.

M. D. or other

Address: 34 Va. Ave Date signed 5/13/40

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

05064

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (154a)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Spring Gap Md Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME David Royce Reckley

3. (b) Social Security Number None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5. 1937

8. AGE: Years 2 Months 8 Days 17 If less than one day hrs. min.

9. Birthplace Spring Gap, Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Merle H Reckley

13. Birthplace Md

MOTHER 14. Maiden name Beulah Knaue

15. Birthplace West Va.

16. Informant Merle H Reckley

Address Spring Gap Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/24/40 (month) (day) (year)

Cemetery or crematory Spring Gap

Location Spring Gap Md.

18. Funeral director Louis Stein Jr

Address Cumberland Md

19. May 24 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1940, at 12 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1940, to May 22 1940, and that I last saw h in live on May 22 1940.

Immediate cause of death: Post Operative Shock — DURATION 2 hrs

Due to Acute Osteomyelitis — 5 mo

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings: Of operations Osteomyelitis involving intra left tibia

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James T Johnson Jr M. D. or other

Address Cumberland Md Date signed 5-24-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12-B)

CERTIFICATE OF DEATH

05065

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD. MEMORIAL HOSPITAL
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hosp.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State West Virginia County Mineral

City or town Keyser Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 150 Center St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME MRS. JESSIE REYNOLDS

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6 (b) Name of husband or wife FRANK C. REYNOLDS

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 12, 1876.

8. AGE: Years	Months	Days	If less than one day
~~64~~ 63	9	24	hrs. min.

9. Birthplace WEST VIRGINIA (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name FLOYD KNIGHT

13. Birthplace MARYLAND

MOTHER 14. Maiden name VALERIA RIDGELEY

15. Birthplace WEST VIRGINIA

16. Informant DR. K. REYNOLDS

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 8, 1940 (month) (day) (year)

Cemetery or crematory Queens Point Cem.

Location Keyser, W. Va.

18. Funeral director Markwood & Son.

Address Keyser, W. Va.

19. May 6, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

MAY 5 1940 11:25 P.M.

20. DATE OF DEATH 19 , at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3, 1940, to May 5 1940, and that I last saw h alive on May 5 1940.

Immediate cause of death Cerebral Embolus — DURATION 1 day

Due to following Operation for Intestinal obstruction — 3 days

Due to due to adhesions

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations band of adhesions constricting bowel

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. M. Wilson M.D. M. D. or other

Address Cumberland Md Date signed 5-5-40

DR. F. WILSON

RECEIVED
JUN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-B)

05066

CERTIFICATE OF DEATH

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Moscow

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 24 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Moscow Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR ✓

3. (a) FULL NAME Guy Dallas Ritchey

201-09-4682 (Coast) **3. (b) Social Security Number** ✓

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Fanny Ritchey

6(c) If alive, give age 68 years

7. Birth date of deceased (mo., day, yr.) June 12, 1874

8. AGE: Years 65 | Months 11 | Days 7 | If less than one day: hrs. min.

9. Birthplace near Martinsburg, Penna.

(Town, county, and state)

10. Usual occupation C. & V. Street car line (loss).

11. Industry or business

FATHER 12. Name James Edward Ritchey

13. Birthplace Clearville, Pa

MOTHER 14. Maiden name Not known

15. Birthplace

16. Informant Mrs. George Maase

Address Baston, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof May 22 1940 (month) (day) (year)

Cemetery or crematory Laurel Hill Cem.

Location Moscow, Md.

18. Funeral director D. S. Beal

Address Baston, Md.

19. May 20 1940 (Date rec'd by registrar) S. A. Boucher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19, 1940, at 11:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 1940, to May 19 1940, and that I last saw h alive on May 19 1940.

Immediate cause of death Myocarditis

DURATION

Due to

Due to

Other conditions Chronic Nephritis

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry Dr. Hodgson M.D.

M. D. or other

Address Lonaconing, Md. Date signed May 21 '40

RECEIVED
JUN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

05067

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany

City or town Midland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 51 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Midland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. —
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Maud M. Harden Robertson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife George Robertson

6(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) September 17, 1879

8. AGE: Years	Months	Days	If less than one day
60	8	14	hrs. min.

9. Birthplace Myersdale, Pennsylvania
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER 12. Name Fred Harden

FATHER 13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

MOTHER 15. Birthplace Pennsylvania

16. Informant George Robertson

Address Midland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 2nd (month) (day) 1940 (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg, Md.

18. Funeral director M. Eichhorn

Address Lonaconing, Md.

19. June 2 1940 E. Don Flo
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1940, at 12:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 14 1940, to May 31 1940, and that I last saw h-er alive on May 28 1940.

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Hypertension	
Due to	
Other conditions Diabetes	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. M. Shelton Jr. M.D.
M. D. or other

Address Midland, Md. Date signed 6-1-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore 170-2

CERTIFICATE OF DEATH

05068

Reg. Dist. No. 6

1. PLACE OF DEATH:
County: Allegany
City or town: McCoole
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Public Road
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: McCoole Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 103 West St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Charles Raymond Robinson

3. (b) Social Security Number: 236-14-1438

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 9, 1918

8. AGE:

Years	Months	Days	If less than one day
22	2	29	hrs. min.

9. Birthplace: Keyser, Mineral, W. Va. (Town, county, and state)
10. Usual occupation: Textile Machine Operator
11. Industry or business: Amicelle Co.

FATHER
12. Name: Earnest W. Robinson
13. Birthplace: Dawson, Md.

MOTHER
14. Maiden name: Margory Liller
15. Birthplace: Romney, W. Va.

16. Informant: E. W. Robinson
Address: McCoole, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 5/11/40 (month) (day) (year)
Cemetery ~~or crematory~~ XXXX Philo Cem.
Location: Westernport, Md.

18. Funeral director: J. H. Markwood Sons
Address: Keyser, W. Va.

19. May 10 1940 (Date rec'd by registrar) A. J. Gaynbaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8 1940, to May 8 1940, and that I last saw him alive on May 8 1940.

Immediate cause of death: Fractured Skull

Due to

Due to auto accident

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

DURATION: 5/8/40 330 pm

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, ~~suicide, or homicide~~ Date of May 8 1940
Where did injury occur? Westernport (City or town) Allegany (County) Md (State)
Injured at home, farm, industry, public place (where?) High Way
Means of injury auto accident Injured at work? No

23. SIGNATURE: Leo Reeves M.D. M. D. or other
Address: Westernport Md Date signed 5/8/40

VS A15 (T) (I) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 5 1940
BUREAU V. S.

Outside of City Limits

M

I

T

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

05069

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: R.D.#2. Cumberland - Rural
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Mexico Farms

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: R.D.#2 Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Mexico Farms
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: William Patrick Ryan

3. (b) Social Security Number: None.

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Widowed

6 (b) Name of husband or wife: Dora Belle Ryan

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Nov. 6, 1863

8. AGE: Years: 76 Months: 6 Days: 8 If less than one day ____ hrs. ____ min.

9. Birthplace: Mackeyville, Penna.
(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER
12. Name: Henry Ryan
13. Birthplace: Penna.

MOTHER
14. Maiden name: Martha (Unknown)
15. Birthplace: Penna.

16. Informant: Mrs. Nora Swan
Address: R.D.#2. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 16, 1940 (month) (day) (year)

Cemetery or crematory: Mt. Pleasant Cem.

Location: Baltimore Pike

18. Funeral director: J. C. Wolford
Address: Cumberland, Md.

19. May 16, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14, 1940, at 11A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3 1940, to May 14 1940, and that I last saw h____ alive on ____ 19____.

Immediate cause of death: Chronic Myocarditis — DURATION: 6 mo ?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: Geo P Paulman M. D. or other

Address: Cumb Md Date signed: May 15 1940

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

05070

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 401 Valley St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 78 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 401 Valley St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Frank A Shober

3. (b) Social Security Number None

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Catherine Worsing

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 5 1861

8. AGE: Years 78 Months 7 Days 27 If less than one day hrs. min.

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual occupation Butcher (Retired)

11. Industry or business

FATHER
12. Name John M. Shober
13. Birthplace Germany.

MOTHER
14. Maiden name Anna M Eschen
15. Birthplace Germany.

16. Informant Frank Shober.

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 6 '40 (month) (day) (year)

Cemetery or crematory Sts Peter & Pauls Cem.

Location Cumberland Md.

18. Funeral director Louis Stein Inc.

Address Cumberland.

19. May 4, 1940 (Date rec'd by registrar) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1940, to May 2 1940, and that I last saw him alive on May 2 1940.

Immediate cause of death Cerebral Hemorrhage — DURATION 2 days

Due to

Due to Hyper Tension Heart disease — some years

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. Alan G. Hemmings Md
M. D. or other

Address 41 Green Ct Cumberland Date signed May 3 '40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

JUN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (3)

CERTIFICATE OF DEATH

05071 5

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cresaptown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days) —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Cresaptown Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME Stillborn Female Carr (Simoned)

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Stillborn

6 (b) Name of husband or wife —
6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) May 26, 1940

8. AGE: Years — Months — Days — If less than one day — hrs. — min.

9. Birthplace Cresaptown Md (Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER
12. Name Woodrow Carr
Birthplace Dry Fork, W. Va.

MOTHER
14. Maiden name Rosalie Simmons
15. Birthplace Jennington W. Va.

16. Informant Rosalie Simons
Address Cresaptown Md

17. Cremation (Burial, cremation, or removal? Which?) Date thereof May 28, 1940 (month) (day) (year)
Cemetery or crematory Hafers
Location Cumberland
18. Funeral director Jacob Hafer
Address Cumberland

19. 5/28/1940 (Date rec'd by registrar) M. L. Trimmer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from did not attend 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Stillborn	
Due to premature birth	
Due to 5 mos	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE Thos. H. Ford M. D. or other
Address — Date signed

RECEIVED
JUN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-A)

CERTIFICATE OF DEATH

05072

Reg. Dist. No. 5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Rawlings
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 10 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Rawlings Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Anna Bell Skelley

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6 (b) Name of husband or wife Joseph Skelley
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 2 1886

8. AGE: Years	Months	Days	If less than one day
53	8	13	hrs. min.

9. Birthplace Franklin W. Va.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Enos Robinson
13. Birthplace W. Va.
MOTHER 14. Maiden name Mary Malone
15. Birthplace W. Va.
16. Informant Joseph Skelley
Address Rawlings Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 4 40 (month) (day) (year)
Cemetery or crematory St Ambrose Cem.
Location Cresaptown Md.
18. Funeral director Young Stein Funeral Home
Address Cumberland
19. 5/2/40 1940 W. Trammell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 1940, at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1938 19 to 5-1 1940 and that I last saw h alive on 5-1-40 19

Immediate cause of death	DURATION
Cardio - vascular renal disease	5 years
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Alfred V2 Long M. D. or other
Address Cumberland, Md. Date signed 5-2-40

RECEIVED
JUN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (157)

WITHIN CORPORATE LIMIT.

Reg. Dist. No. 9

05073

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town Frostburg
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: 212 Center St

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 40 hrs

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Allegany

(c) City or town Frostburg
(If outside city or town limits, write RURAL and give town)

(d) Street No. 212 Centre St.
(If rural give location)

(e) If foreign born, how long in U. S. A.? _____ years

3 (a) **FULL NAME** Baby Stidmore

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: Male

5. Color or race: W

6 (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24 1940

8. **AGE:** Years | Months | Days | If less than one day: hr. 40 min.

9. Birthplace Frostburg Md
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER

12. Name Jonas Stidmore

13. Birthplace Frostburg

MOTHER

14. Maiden Name Thelma A. Davis

15. Birthplace Frostburg

16 (a) Informant Jonas Stidmore

(b) Address Frostburg Md

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 5/24/1940 (month) (day) (year)

(c) Cemetery or crematory Allegheny

Location Frostburg Md

18 (a) Funeral director Pearce A. Stidmore

(b) Address 16 Fairview Ave. Frostburg

19 (a) 5-24-1940 (Date rec'd by registrar) (b) mrs. A. C. Walker Registrar

MEDICAL CERTIFICATION

20. Date of death May 24 1940, at 1:45 P M

21. I certify that death occurred on the date above stated; that I attended deceased from May 24 1940, to May 24 1940, and that I last saw him alive on May 24 1940.

Immediate cause of death	Duration
Prematurity	45 min
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. **Signature** W M Sanders M.D. (M. D. or other)

Address Frostburg Md Date signed May 24 1940

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 3 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05074

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Westernport
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Reeves Clinic
Stay in hospital or inst. (yrs., or mos., or days) 11 days
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Garrett
City or town Barton Rural Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 7 mi W. of Barton
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Harold Lee Smith

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 17, 1932

8. AGE: Years 7 Months Days 26 If less than one day hrs. min.

9. Birthplace ("Town") Barton, Garrett, Md.
(Town, county, and state)

10. Usual occupation Student.

11. Industry or business Grade School

FATHER
12. Name Elmer Porter Smith
13. Birthplace "New" Barton Md.

MOTHER
14. Maiden name Mary C. Broadwater
15. Birthplace "New" Barton, Md.

16. Informant E. P. Smith
Address Barton, Md. Route 1

17. Burial Date thereof May 8, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Rhodes Cemetery
Location 7 Mi. W. of Barton, Md.

18. Funeral director D. S. Bopp
Address Westernport, Md.

19. May 6 1940 A. Frazin Baker M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apl. 25 1940, to May 5 1940, and that I last saw h— alive on May 5th 1940.

	DURATION
Immediate cause of death Myo. Carditis acute + Endocarditis	4/25/40
Due to Rheumatic fever	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. O. Reeves, M.D.
M. D. or other
Address Westernport Md Date signed 5/6/40

RECEIVED
JUN 5 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

05075

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 505 Central Ave.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Mr. Henry Smith

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6 (b) Name of husband or wife: Emma Hammond
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 21, 1855

8. AGE: Years: 85 Months: 3 Days: 29 If less than one day: hrs. min.

9. Birthplace: Pittsburgh, Penna (Town, county and state)

10. Usual occupation: Carpenter

11. Industry or business:

FATHER 12. Name: Henry Smith
13. Birthplace: Germany

MOTHER 14. Maiden name: Leanora Leymann
15. Birthplace: Germany

16. Informant: Mrs Eleanora Leuthold
Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 22 1940 (month) (day) (year)
Cemetery or crematory: Trinity Lutheran Cem
Location: Cumberland Md

18. Funeral director: Louis Stein Sons
Address: Cumberland Md

19. May 22 1940 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 20, 1940, at 3:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 May 20 1940 to 19 May 18 1940, and that I last saw h[illegible] alive on 19

Immediate cause of death: Chronic Myocarditis

Due to: Generalized Arteriosclerosis

Due to: Accidental fall, in her home

Other conditions: Fracture neck of femur. Due to an accidental fall.

(Include pregnancy within 3 months of death) Duration: ? ? 1939

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Accident Date July 4th, 39
Where did injury occur? Home, Cumberland, Md (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) in her Home
Means of injury: Injured at work?

23. SIGNATURE: W Royce Hodges, Jr., MD M. D. or other
Address: Cumberland Md Date signed 5/20/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUN 6 1940
BUREAU V. S.

Outside of City Limits

FORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

05076

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Rural, near Cumberland.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Bedford Road

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 60 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Rural near Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Bedford Road.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Sarah Elizabeth Cook Smouse

3. (b) Social Security Number None

4. Sex Female

5. Color or race White

6. (a) Single, married, widowed, or divorced married.

6 (b) Name of husband or wife Chas. Smouse

6(c) If alive, give age 83 years

7. Birth date of deceased (mo., day, yr.) Oct 10, 1858

8. AGE: Years 81 Months 7 Days 11 If less than one day ___ hrs. ___ min.

9. Birthplace Wellersburg, Somerset, Pa
(Town, county, and state)

10. Usual occupation House work

11. Industry or business At Home

FATHER
12. Name Jesse Cook
13. Birthplace Wellersburg, Pa

MOTHER
14. Maiden name Sarah Hoyman
15. Birthplace Somerset County, Pa.

16. Informant Chas. Smouse
Address Bedford Road-Cumberland Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof May 26, 1940
(month) (day) (year)

Cemetery or crematory Zion Memorial

Location Bedford Road,

18. Funeral director Jacob Hafer.

Address Cumberland Md.

19. May 24, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21 1940, at ___ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 9, 1940, to May 20 1940, and that I last saw her alive on May 18 1940.

Immediate cause of death Paroxysmal Cardiac dyspnea.

Due to dyspnea

Due to Generalized Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

DURATION
?

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE W Royce Hodges, M.D.
M. D. or other

Address Cumberland, Md Date signed 5/2

Hodges

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(I)

(T)

RECEIVED
JUN 6 1940
BUREAU V. S.

Outside of City Limits

CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(74a)

05077

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Rural near Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Baltimore Pike National Hwy

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Rural near Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. National Hwy. east

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Joseph Valentine Stegmaier

3. (b) Social Security Number None

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Helen Lindner

6(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) Feb 5 1882

8. AGE: Years 58 Months 3 Days 5 If less than one day ___ hrs. ___ min.

9. Birthplace Cumberland Md.

(Town, county, and state)

10. Usual occupation Dairey Farm.

11. Industry or business

FATHER 12. Name Leonard Stegmaier

13. Birthplace Germany.

MOTHER 14. Maiden name Gertrude Heck.

15. Birthplace Germany.

16. Informant Helen Stegmaier

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 13 40 (month) (day) (year)

Cemetery or crematory St Peter & Paul's Cem

Location Cumberland

18. Funeral director Louis Stein Inc.

Address Cumberland

19. May 13 1940 J. P. Franklin, M. D.

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 1940, at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 4 1940, to May 10 1940, and that I last saw him alive on May 10 1940.

Immediate cause of death Lymphatic Leukemia. DURATION 6 mos.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos. W. Hoon M. D. or other

Address Cumberland Date signed May

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

05078

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany County.

City or town: Frostburg, Maryland.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 79 Bowery St.

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 50 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 79 Bowery St.
(If rural, give LOCATION)

2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME: Belle Beeman Stevenson

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, ~~widowed, or divorced~~: Married

6 (b) Name of husband or wife: John M. Stevenson

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): April 29, 1865

8. AGE: Years: 75 Months: 0 Days: 19 If less than one day: ____ hrs. ____ min.

9. Birthplace: Midland Md
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at Home.

FATHER 12. Name: Sam. Beeman

13. Birthplace: Md

MOTHER 14. Maiden name: Louise Miller

15. Birthplace: Md

16. Informant: Marie Duckworth

Address: 2028, 13th st Akron Ohio

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20, 1940 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg, Md.

18. Funeral director: Jacob Kaufer

Address: Frostburg, Md.

19. 5-20-1940 (Date rec'd by registrar) Mrs. A. R. Parker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/18/40 19____, at 1 P. M.

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from 1/13/39 19____, to 2/10/39 19____, and that I last saw h ER alive on 2/10/39 19____.

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ____ Injured at work?

23. SIGNATURE: Glen Kilday M. D.
M. D. or other

Address: Frostburg, Md. Date signed 5/20/40

RECEIVED
JUN 3 1940
BUREAU V. S.

Outside of City Limits

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (157-g)

Reg. Dist. No. 4

05079

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

(a) County Allegany

(b) City or town R. D. 3. Bedford Rd.
(If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution:

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days)

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Md. (b) County Allegany.

(c) City or town R. D. #3. Cumberland.
(If outside city or town limits, write RURAL and give town)

(d) Street No.
(If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Nancy Jane Thompson

3 (b) If veteran, name war

3 (c) Social Security No. None

4. Sex Female

5. Color or race white

6 (a) Single, married, widowed, or divorced. Infant.

6 (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 1, 1940.

8. AGE: Years | Months | Days 30 | If less than one day hr. min.

9. Birthplace Cumberland, Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Russell Thompson.
13. Birthplace Mt. Union Penna.

MOTHER
14. Maiden Name Florence Frantz
15. Birthplace R. D. #3, Cumberland, Md.

16 (a) Informant Russell Thompson
(b) Address R. D. 3. Cumberland. Md.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof May 31, 1940. (month) (day) (year)

(c) Cemetery or crematory Zion Memorial Park

Location Bedford Rd.

18 (a) Funeral director J. C. Wolford

(b) Address Cumberland, Md.

19 (a) May 31, 1940 (Date rec'd by registrar) (b) J. P. Franklin, M. D. Registrar

MEDICAL CERTIFICATION

20. Date of death May 31, 1940, at 4:00 A. M.

21. I certify that death occurred on the date above stated; that I attended deceased from May 1 1940, to May 31 1940, and that I last saw him alive on May 31 1940.

Immediate cause of death Pneumonia. The result of inability to swallow properly.

Due to Complete Cleft Palate & hair lip.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

Duration: 3 days

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature R. C. Bowen M. D.
M. D. or other

Address Cumberland Date signed 5-31-40

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

05080

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: MEMORIAL HOSPITAL

Stay in hospital or inst. (yrs., or mos., or days) 6 hours

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 28 FRONT STREET (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME MR. JOHN DENNIS TWIGG

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
MALE	WHITE	SEPARATED

6 (b) Name of husband or wife MARY SHRYOCK 6(c) If alive, give age 58 years

7. Birth date of deceased (mo., day, yr.) Sept. 25, 1875

8. AGE: Years	Months	Days	If less than one day
64	7	21	hrs. min.

9. Birthplace MARYLAND (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business General farming

FATHER 12. Name WILLIAM TWIGG

13. Birthplace MARYLAND

MOTHER 14. Maiden name AMELIA CASTEEL

15. Birthplace MARYLAND

16. Informant MRS. HILL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 18, 1940 (month) (day) (year)

Cemetery or crematory Mt. Tabor Cemetery

Location Spring Gap, Md.

18. Funeral director Jacob Hofer

Address 1730 Baltimore Ave.

19. May 17, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. WILLIAMS

MEDICAL CERTIFICATION

20. DATE OF DEATH MAY 16, 1940 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/15/40 to 5/16/40 and that I last saw him alive on 5/16/40

Immediate cause of death Cerebral Hemorrhage — DURATION

Due to Hypertension

Due to Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard L. Williams M.D. M. D. or other

Address 34 Va. Ave Date signed 5/16/40

Cumberland Md

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS,

05081

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(93d)

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 1318 Virginia Ave.

Stay in hospital or inst. (yrs., or mos., or days) 45 yrs.

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1318 Va. Ave.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME John Wm. Wagner

3. (b) Social Security Number

4. Sex Male

5. Color or race White

6. (a) Single, married, widowed, or divorced Divorced

6 (b) Name of husband or wife Sarah Gunther

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 1 1872

8. AGE: Years 68 Months 4 Days 18 If less than one day hrs. min.

9. Birthplace W. Va.

(Town, county, and state)

10. Usual occupation Employee

11. Industry or business R.R. Co

FATHER

12. Name Joseph Wagner

13. Birthplace W. Va.

MOTHER

14. Maiden name Ellen Smith

15. Birthplace W. Va.

16. Informant Mrs Florence Rankin

Address Cumberland

17. Burial (Burial, cremation, or removal, Which?) Date thereof May 22 1940 (month) (day) (year)

Cemetery or crematory Rose Hill Cem

Location Cumberland Md

18. Funeral director Louis Stein Inc

Address Cumberland Md

19. May 22 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1940, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 15 1940, to May 19 1940

and that I last saw him alive on May 19 1940

Immediate cause of death Cardio Vascular disease

DURATION about 1936

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. G. Owen M. D. or other

Address 137 Va Ave Date signed May 20,

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M) (T) (I)

RECEIVED
JUN 6 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (146-C)

05082

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hosp.
Stay in hospital or inst. (yrs., or mos., or days): 10 hours
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: West Virginia County: Mineral
City or town: Ridgeley Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Millerdale
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR: ✓

3. (a) FULL NAME: Margaret Helene Weakley

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6 (b) Name of husband or wife: Isaac Weakley
6(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): Sept 9 1917

8. AGE: Years	Months	Days	If less than one day
22	8	0	hrs. min.

9. Birthplace: Brunswick Md (Town, county, and state)
10. Usual occupation: House duty
11. Industry or business: Own Home
FATHER 12. Name: John Reynolds
FATHER 13. Birthplace: Brunswick Md
MOTHER 14. Maiden name: Margaret Walker
MOTHER 15. Birthplace: Brunswick Md
16. Informant: Isaac Weakley
Address: Ridgeley W Va
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 11, 1940 (month) (day) (year)
Cemetery or crematory: Mt Hermon Cemetery
Location: Williams Road
18. Funeral director: Wm H. Kight
Address: Cumberland Md
19. May 11, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9-1940 19 12 50 a.m. P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8th 1940, to May 9 1940, and that I last saw her alive on May 8 1940

Immediate cause of death	DURATION
Postpartum hemorrhage (Uterine Retention)	40 Min
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: P. M. Jurewskis M.D. M. D. or other
Address: Cumberland, Md Date signed: May 9

RECEIVED
JUN 1 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-A)

05083

CERTIFICATE OF DEATH

Reg. Dist. No. ____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Alleganey
City or town: Moscow
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Moscow, Md.
Stay in hospital or inst. (yrs., or mos., or days): 42 yrs
Stay in this community (yrs., or mos., or days): ____

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Alleganey
City or town: Moscow. Ward No. ____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. ____
(If rural, give LOCATION)
2(a) IF VETERAN, NAME WAR: World

3.(a) FULL NAME: Vernon William Wiland.

3.(b) Social Security Number: 383-05-0642

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Ruth Russell Wiland
6(c) If alive, give age: 38 years
7. Birth date of deceased (mo., day, yr.): April 5, 1897.
8. AGE: Years: 43 Months: 1 Days: 3 If less than one day: ____ hrs. ____ min.
9. Birthplace: Moscow-Alleganey- Md.
(Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: Gasoline station
FATHER 12. Name: Henry Wiland
FATHER 13. Birthplace: Lonaconing, Md.
MOTHER 14. Maiden name: Ella Dorsey
MOTHER 15. Birthplace: Moscow, Md.
18. Informant: Ruth R. Wiland
Address: Moscow, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 11, 1940 (month) (day) (year)
Cemetery or crematory: St. Michaels
Location: Frostburg, Md.
18. Funeral director: D. S. Boal.
Address: Westernport, Md.
19. May 10 1940 (Date rec'd by registrar) S. A. Boucher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8 1940, at 12:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2, 1940 1940, to May 4 1940, and that I last saw him alive on May 8 1940.

	DURATION
Immediate cause of death: Cerebral Hemorrhage	1 day
Due to: Hypertension	2
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Joseph Friedman M. D. or other
Address: Westernport Date signed: May 9, 1940

RECEIVED
JUN 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

05084

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 105 1/2 W. Main St.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): All her life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 105 1/2 W. Main Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Ida Jane Williams

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James E. Williams

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Oct 16 1871

8. AGE: Years 68 Months 7 Days 18 If less than one day ____ hrs. ____ min.

9. Birthplace: Carlos, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Benj. Wilson
13. Birthplace: Md.

MOTHER
14. Maiden name: Lost Know.
15. Birthplace: Md.

16. Informant: James E. Williams
Address: 105 1/2 W. Main St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 7 1940 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: Jacob Kafer

Address: Frostburg, Md.

19. May 7th 1940 (Date rec'd by registrar) Mrs. A. R. Hacker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5 1940, at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 28 1940, to May 3 1940, and that I last saw her alive on May 4 1940.

Immediate cause of death: Cerebral Hemorrhage — DURATION: 1 wk

Due to: Arteriosclerosis — ?

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings:

Of operations: no

Of autopsy: no

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. O. McLane Jr. M.D. M. D. or other

Address: Frostburg Md. Date signed: May 7 1940

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-9)

05085

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days) 23 days

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Westernport Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME WILLIAM CURTIS WILSON

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 2, 1940

8. AGE: Years	Months	Days	If less than one day
	1	26	hrs. min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Infant

11. Industry or business

FATHER
12. Name George Wm. Wilson
13. Birthplace Maryland

MOTHER
14. Maiden name Addie Wiltison
15. Birthplace West Virginia

16. Informant Geo. W. Wilson
Address Westernport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 29. 1940 (month) (day) (year)

Cemetery or crematory Philos

Location Westernport Md.

18. Funeral director David S. Boal
Address Westernport Md.

19. May 28 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May. 28 1940, at 7 5/9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May. 5 1940, to May. 28 1940, and that I last saw him alive on May. 27 1940.

Immediate cause of death Pyloric stenosis — DURATION 6 Wks

Due to Congenital

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings: Of operations Pyloric Stenosis

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. W. Ellison M.D. M. D. or other

Address 126 Yman St. Cumberland Md. Date signed 5/28/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUN 6 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (126)

CERTIFICATE OF DEATH

Reg. Dist. No. 1 05086

1. PLACE OF DEATH:
County: Allegany
City or town: Mt. Savage Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Mt. Savage Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Sara Elizabeth Wingfield

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Wm. Wingfield
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): February 16, 1877

8. AGE: Years 63 | Months 3 | Days 13 | If less than one day ____ hrs. ____ min.

9. Birthplace: Flintstone Md. (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business: home

FATHER
12. Name: John L. Bennett
13. Birthplace: Maryland

MOTHER
14. Maiden name: Maisie Perdew
15. Birthplace: Maryland

16. Informant: Carl Wingfield
Address: Mt. Savage Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 1, 1940 (month) (day) (year)
Cemetery or crematory: Methodist Cemetery
Location: Mt. Savage Md.

18. Funeral director: J. J. Durst,
Address: Frostburg Md.

19. May 30 1940 (Date rec'd by registrar) H. J. Bostetter M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 28 1940, at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 12 1940, to May 28 1940, and that I last saw her alive on May 26 1940.

Immediate cause of death: Cirrosis of liver
Due to: Obstruction of common duct
Due to:
Other conditions: Gall bladder filled with stone ruptured.
(Include pregnancy within 3 months of death)
Major findings: Ruptured gall bladder
Of operations: Common duct almost closed from cirrosis.
Of autopsy:

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? ____ (City or town) ____ (County) ____ (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: S. E. Enfield M. D. or other
Address: Cumberland Md. Date signed 6/29/40

RECEIVED
JUN 3 1949
BUREAU V. S.

WITHIN CORPORATE LIMITS.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

05087

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days) 3 days

Stay in this community (yrs., or mos., or days) 15 years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 453 Goethe St. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME James Clifton Winner

3. (b) Social Security Number 217-10-1039

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Raphael Parker Winner

6 (c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Jan 7, 1890

8. AGE: Years 50 Months 3 Days 23 If less than one day ____ hrs. ____ min.

9. Birthplace Frostburg Md (Town, county, and state)

10. Usual occupation Barber

11. Industry or business Barber Shop

FATHER 12. Name Harmon Winner

13. Birthplace Carlos Md

MOTHER 14. Maiden name Laura Crowe

15. Birthplace Knapps Meadow Md

16. Informant Verner Winner

Address Goethe St Cum.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 6, 1940 (month) (day) (year)

Cemetery or crematory St Michaels

Location Frostburg Md

18. Funeral director Jacob Hafer

Address Cumberland

19. May 6, 1940 J. P. Franklin, M. D. (Date rec'd by registrar) Registrar

Dr Grove

MEDICAL CERTIFICATION

20. DATE OF DEATH May 3, 1940, at 1:25 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 30 1940, to May 3 1940, and that I last saw him alive on May 2, 1940 19____.

Immediate cause of death: 3rd degree burns of face, neck, chest

Due to: Shock — A burning building was involved.

Due to: Toxemia — Patient burned while sleeping.

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations none

Of autopsy none

DURATION: 3 days; 2 days

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 4/30/40

Where did injury occur? North Branch, Alleg. Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home.

Means of injury fire Injured at work? no

23. SIGNATURE D. B. Grove, M.D. M. D. or other

Address Medical Bldg Date signed 5/4/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
MAY 13 1940
BUREAU V. A